FFY 2022-2023BEHAVIORAL HEALTH ASSESSMENT AND PLAN
DRAFT

Substance Abuse Prevention and Treatment

Block Grant (SABG)

Strengths and Organizational Capacity of the Service System

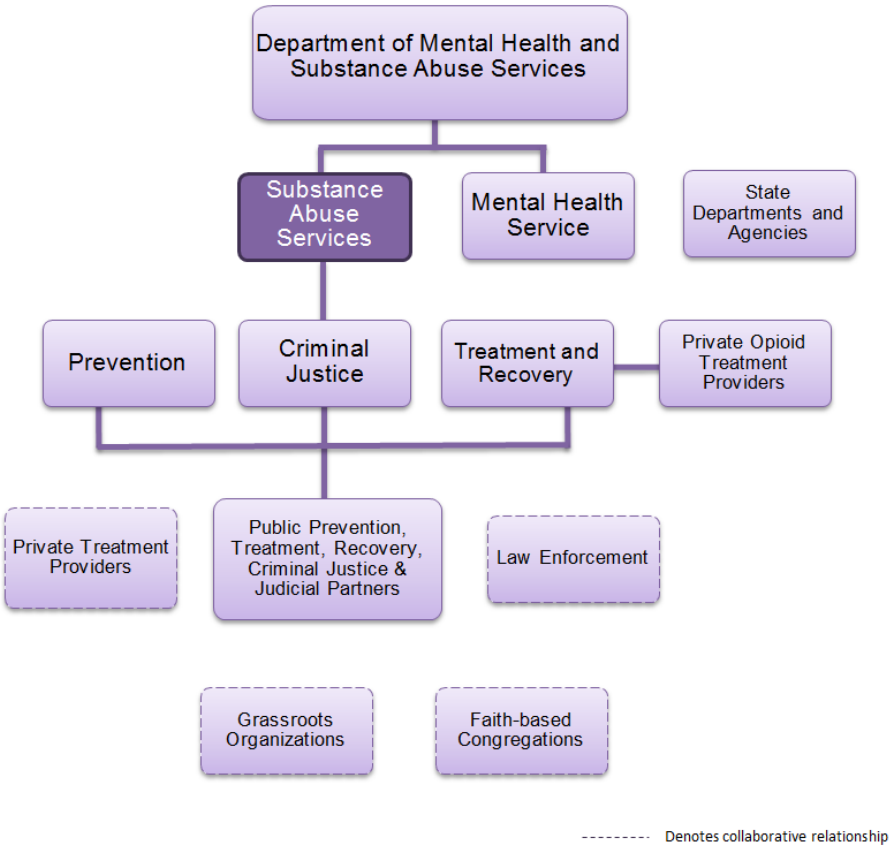
Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

The Department of Mental Health and Substance Abuse Services (TDMHSAS) serves as Tennessee's substance use disorders, mental health and opioid authority. The Department is responsible for system planning; setting policy and quality standards; licensing personal support services agencies, substance abuse and mental health services and facilities; system monitoring and evaluation; and disseminating public information and advocacy for persons of all ages who have a substance use, mental or co-occurring disorder, including serious emotional disturbance. TDMHSAS also provides inpatient psychiatric services for adults, including acute, subacute, and secure forensic beds, through its operation of four fully accredited Regional Mental Health Institutes (RMHIs). Listed below and hereafter is Tennessee's substance abuse system.

Tennessee's Substance Abuse System

Substance abuse is a pervasive public health issue. It has roots in individual, family, peer, and community conditions that shape risk for experiencing substance abuse and its consequences. It negatively impacts families and children; increases crime and threatens public safety; and imposes tremendous social and economic cost to society. Not surprisingly, these pervasive social manifestations prompt responses across our public and private institutional systems. While it is difficult to paint a precise picture of the entire system for serving individuals experiencing substance abuse and its consequences, the information below helps to establish the parameters of the role currently played by TDMHSAS, Division of Substance Abuse Services (DSAS) within the entire state system. Understanding the context of this information is important for making realistic strategic decisions about how DSAS' role may be defined more effectively in the future, and how that role may be coordinated with other components of the full system of service for substance abuse and related problems.

Tennessee Substance Abuse System



The ***Division of Substance Abuse Services*** receives and administers federal block grant and state funding for substance abuse services. Our mission is to create collaborative pathways to resiliency, recovery, and independence for Tennesseans living with mental illness and substance use disorders. One of ***DSAS' strengths*** is its' integrated substance abuse system. This system consists of: providers, state departments, state agencies, judicial courts, grassroots organizations and faith-based organizations that are collaborating to provide an effective and efficient delivery of mental health and substance abuse services to Tennesseans.

According to the National Survey of Substance Abuse Treatment Services (N-SSATS), in 2020, the overall Tennessee treatment system included 311 facilities. 63% were private non-profit facilities and 35.4% were private for-profit agencies. ***DSAS purchases services directly from non-profit and for-profit providers; and has established a partnership that is transparent and respectful.***

Profile of Tennessee Treatment Facilities

Type of Facility	Number of Facilities	Total Number of Clients
Private non-Profit	196	7,991
	63%	42.4%
Private for-Profit	110	10,294
	35.4%	54.6%
Public	5	580
	1.6%	3%
Total	311	18,865
	100%	100%

DSAS works closely with its' Sister Division, ***Mental Health Services,*** to provide community-based programs and services. The Division of Mental Health Services is responsible for planning and promoting a comprehensive array of services and supports for individuals of all ages, living with mental illness and/or serious emotional disturbances. The Divisions collaborate on activities to train and educate the community on suicide prevention and the linkage to substance use disorder; provide support for the certified peer recovery specialists program and work to employ individuals with lived experiences; and criminal justice diversion strategies to help prevent individuals from re-entry into and/or out of jail or prison.

The Opioid Crisis has afforded DSAS the opportunity to partner with ***private substance abuse treatment providers*** and ***Opioid Treatment Programs*** (OTPs). The overarching goal is to "Create No Wrong Door to Access for Opioid Addiction in Tennessee". Multiple meetings were held, and subcommittees established to address how public/private collaborations can improve Tennessee's behavioral health system. A joint plan of action was developed to address Tennessee's Psychiatric Care Delivery System.

In Tennessee, Opioid Treatment Programs (OTPs) are for-profit agencies. TDMHSAS licensed ***Opioid Treatment Programs*** and the State Opioid Treatment Authority (SOTA) provides administrative, medical, and pharmaceutical oversight to certified opioid treatment programs. Through the federal opioid funding and state appropriations, DSAS has expanded its medication assisted treatment network to include OTPs.

DSAS has forged vital relationships with other ***state departments and agencies*** to improve coordination of care for individuals with substance use disorders. Formal partnerships have been established with the Departments of Agriculture, Correction and Health; and Tennessee Bureau of Investigation. These partnerships allow for data sharing, prevention education and treatment services. Over the last couple of years, TDMHSAS' working relationship has grown with TennCare, Tennessee's Medicaid program. Also, DSAS serves as the subject matter experts for the Department of Children's Services ***Zero To Three Court Initiative*** to improve outcomes for infants, toddlers and families involved in the child welfare system. The community coalitions partner with the Tennessee Department of Environment and Conservation to place permanent drug collection boxes in law enforcement agencies. The Office of Criminal Justice Programs allocated $500,000 to DSAS to distribute and train law enforcement agencies on naloxone, opioid use disorder and stigma.

Grassroots organizations are the foot soldiers of the community. DSAS has brought a formal structure to existing organizations, assisted communities establish coalitions, and provided technical assistance on how to develop strategies, utilizing the Strategic Prevention Framework (SPF), to help prevent substance use and abuse. SPF ensures that the strategies are culturally appropriated and sustainable for the community. Local/county entities also assist with the delivery of prevention services. Many of the entities that serve as fiscal agents for our state-funded community coalitions are county entities that are donating space and other resources to ensure that their community coalition is effective and sustained into the future.

Establishing a relationship with the ***Judicial System and local law enforcement agencies*** has been essential to developing a structure for coordinating a system of care for non-violent offenders incarcerated or at risk of incarceration due substance use and abuse. There are thirty-one Judicial Districts in Tennessee. DSAS has joined forces with the General Sessions, Circuit, Criminal, Juvenile, Drug, Mental Health, Veteran, Family Court and Human Trafficking Courts, to coordinate behavioral health care for adult and juvenile offenders. Partnerships with law enforcement agencies have been essential for the community coalitions to assist with Take Back events, disposal of drugs collected and training on overdose prevention and naloxone.

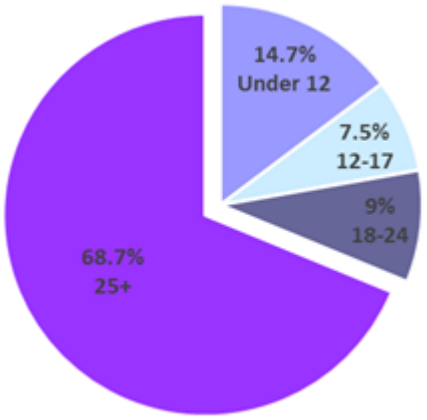
DSAS has built a cohesive prevention, treatment, and recovery network with ***Faith-Based Congregations/Organizations*** to support a common goal of strengthening individuals and families dealing with substance use disorders; and ultimately, restoring our communities.

The goals of the Faith-Based Initiative are to:

- Connect individuals struggling with addiction to treatment
- Increase knowledge of what addiction
- Facilitate understanding of substance use disorder treatment and recovery
- Understand the continuum of care and collaborate with it
- Spread awareness of the Faith-Based Initiative certification and its requirements
- Help groups understand and implement the best practice model
- Promote and improve effectiveness of the faith-based initiative and how it connects the community with recovery and support services

To understand how substance abuse services are delivered in Tennessee, it is important to understand the nature of the substance abuse problem and characteristics of the state's residents—including where populations are concentrated and how many people are approximately at risk. Tennessee is located in the South Eastern portion of the U.S. and is the 16th most populous state in the nation, with an estimated 6,829,174 residents (Census 2019 estimate). The population is predominantly White (72.2 percent) or African American (15.8 percent) with persons of other races comprising approximately two percent of the total resident population. Nearly one-quarter (22.1 percent) of the overall population are under the age of 18. This presents the possibility of substantial cohort effects if substance abuse intervention and treatment among youth can be implemented effectively. Cohorts whose rates of use are lowered tend to keep those lower rates throughout the aggregated lifetimes of their members. That is, a group of 18 year olds who have their use rates lowered should keep comparatively lower rates compared to other cohorts even when they are in middle age or become elderly. However, both the 12–17 and 18–25 age cohorts represent the smallest population size.[1]

Exhibit 1.1
2019 Tennessee Population by Age Category
U.S. Centers for Disease Control (CDC)

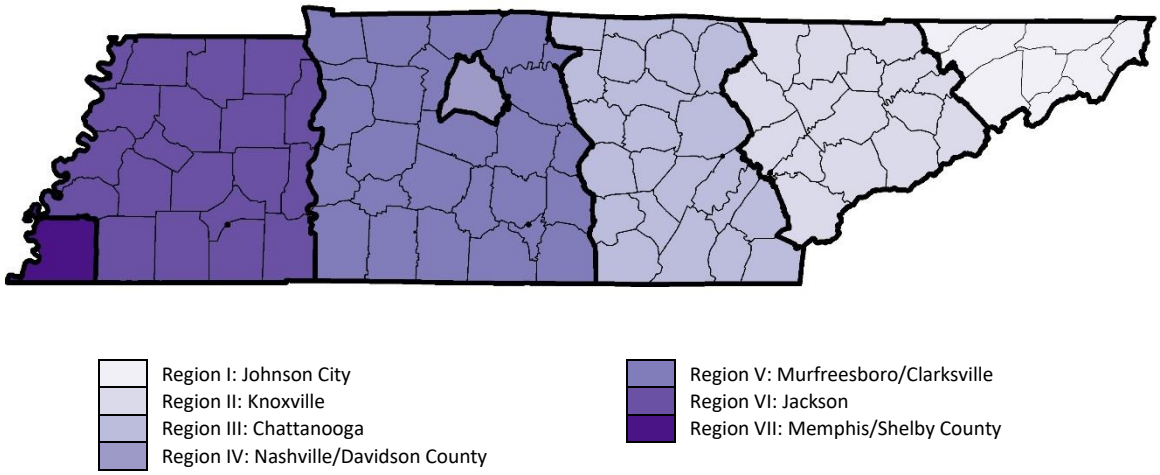


Populations in Tennessee by Age Range		
Age	Population	Percent
Under Age 12	1,003,376	14.7%
Age 12–17	514,793	7.5%
Age 18–25	617,043	9%
Age 26 or Older	4,693,962	68.7%
All Ages	6,829,174	

There are also seven geographic regions across Tennessee that have been established as state behavioral health planning or sub-State Planning areas. These regional designations allow for geographic analysis of survey data on prevalence rates and needs for treatment, as well as service utilization information provided by the State of Tennessee, Division of Substance Abuse Services. The seven Mental Health Planning Regions in Tennessee are displayed below.

[1] Statewide Assessment of Substance Use Disorders Prevention & Treatment Needs, *A Profile of Priority Needs for Prevention and Treatment, Current System Capacity and Services, and Implications for Service Priorities and Development,* State of Tennessee, 2013.

Tennessee Mental Health Planning Regions



State funding resources remained stable for many years. Therefore, DSAS worked to develop and implement "low cost, high impact" programs to expand, enhance and strengthen DSAS' substance abuse services and state and community partnerships. Examples of "low cost, high impact" programs are:

- Community Coalitions
- DUI Schools
- Oxford Houses
- Faith-Based Recovery Network
- Lifeline Peer Program
- Alcohol and Drug Addiction Treatment Program
- Supervised Probation Offender Treatment Program
- Community Treatment Collaborative
- Recovery Courts
- Criminal Justice Liaisons Program
- TN Recovery Oriented Compliance Strategy
- Regional Overdose Prevention Specialists

In 2017-2018, it was estimated that 458,950 Tennesseans, age 18 years and older, have a substance use disorder. Of that group, 52,180 (11.3%) are estimated not to have insurance (NDSUH 2017-18). Recognizing the increasing need for substance abuse prevention, treatment and recovery services, DSAS proactively sought out federal discretionary grant funds to leverage the SABG Block Grant and state appropriations with the goal of helping to close the gap of the number of Tennesseans needing substance abuse services. Since 2018, DSAS has received twenty-one (21) state and federal grants, including STR and SOR.

Prevention Services

DSAS' Prevention structure has three service components to address the prevention needs of individuals, communities, regions, and the State. This structure provides the essential framework and resources necessary to reach Tennessee's high need communities to increase protective factors while decreasing risk factors. Prevention service components included: provider agencies, prevention coalitions, and regional workgroups. Within this system, high need communities and populations are identified by a State Epidemiological and Outcomes Workgroup (SEOW) assessment. ***Provider agencies*** deliver culturally appropriate selected and indicated programs per an assessment through the Tennessee Prevention Network program. A network of county-level ***coalitions*** whose work is governed by the Strategic Prevention Framework (SPF) is the cornerstone of the prevention structure. They work to reduce underage alcohol use, underage tobacco use, and prescription drug use across the lifespan by working within their home communities to implement data-based plans that endeavor to solve the problems in their community through environmental and community-based strategies. Additionally, the Coalition for Healthy and Safe Campus Communities serves the Higher Education Institutions in Tennessee, a population known to be at great risk of alcohol and drug misuse. There are currently 48 anti-drug coalitions that are serving 75% of Tennesseans. Regional Overdose Prevention Specialists (ROPS) have been embedded in county coalitions to provide a regional hub to plan and coordinate evidenced-based and emerging practices to maximize community involvement. ROPS work collaboratively with coalitions and communities to ensure that key stakeholders across the state receive training on: opioid overdose, opioid use disorder, harm reduction, stigma, and naloxone use. In addition to providing training, ROPS distribute naloxone to individuals at high risk of overdose and other key stakeholders in the community. ***Regional Workgroups*** deliver universal indirect interventions, which leverage the efforts of individual coalitions and program providers by implementing environmental strategies in all areas of the state, including those areas without direct funding or a stand-alone program or coalition.

The planning process allows different programs to meet the needs of the predominant high-risk populations within their community. One unique program is the Deaf and Hard of Hearing program which serves the selective population of deaf and hard of hearing youth ages 6-20 and their families. Other prevention services programs include: School-Based Substance Abuse Liaisons, Comprehensive Alcohol, Tobacco and other Drug Program, Synar and Partnerships for
Success. All programs work to understand the unique diversity of the participants they are serving and have cultural humility in their relationships. Cultural humility incorporates a consistent commitment to learning and reflection, but also an understanding of power dynamics and one's own role in society. It is based on the idea of mutually beneficial relationships rather than one person educating or aiding another in attempt to minimize the power imbalances in client-professional relationships.

DSAS also supports prevention programs that address the needs of diverse racial, ethnic, sexual, gender, minorities and military personnel. One example is Just Us, a program that focuses on LGBT youth in the Middle Tennessee area. This program provides a safe place for LGBT youth to come and be validated for their authentic selves; to learn how to use their voices to create change; and to be empowered with the tools to safely navigate the world that is uniquely theirs. Other populations identified as at-risk included, youth with low school performance, delinquency, and/or high school dropouts, rural populations, and college students. The planning process allows different programs to meet the needs of the predominant high-risk populations within their community.

The purpose of implementing the SPF process is to ensure that the strategies and practices implemented as part of the SAPT Block Grant are effective, culturally appropriate, and sustainable. The SPF is a 5-step planning process that includes a comprehensive community assessment that guides the selection,

implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. The assessment helps communities discern what their community looks like in terms of who makes up their community as well as the community consumption patterns or the way people drink, smoke and use illicit drugs. This information ensures that the strategies that are implemented are designed specifically to prevent others from using substances in a similar manner. The ultimate goal of SPF implementation is outcomes-based prevention that focuses on population level change, emphasizing data-driven decision making. Cultural competence is a key portion of the SPF. It is part of each step of the process and is always a key consideration.

The State coordinates prevention activities through the Tennessee Prevention Advisory Council (TN-PAC). TN-PAC expands and strengthens prevention resources, reduces barriers, and increases communication throughout the prevention system. TN-PAC's members are comprised of state agencies; statewide organizations; regional prevention providers (including coalitions); and the Director of Prevention Services. Its structure and membership intentionally reflect the diverse racial, ethnic, faith, socioeconomic and professional sectors of the State. The Evidence-Based Practices Workgroup has operationalized the definition of Evidence Based Practice (EBP) in Tennessee and serves as the expert panel to determine the viability of proposed interventions through a rigorous review and approval process. The SEOW profiles and prioritizes population needs, resources, service gaps and readiness capacity. It provides guidance to the comprehensive strategic planning process at state and community levels, and makes data-informed recommendations to the TN-PAC.

The Prevention Alliance of Tennessee (PAT) is a coalition of coalitions. This group represents all of the prevention coalitions within Tennessee, both those funded by the State as well as those coalitions who are not funded. The PAT allows coalitions in Tennessee to speak with a collective voice related to prevention issues in the State. The PAT has developed committees that develop white papers around topics important to the prevention system (i.e. marijuana legalization, prescription drug policies, etc.). Additionally, the PAT provides training and technical assistance to coalitions across the State

The Office of Prevention Services coordinates with several state agencies to best deliver prevention services. The Department of Health is very interested in many of the substance misuse and abuse issues because they impact the physical health of many Tennesseans. The Department of Health (TDH) is also interested in the prescription drug problem and has partnered with the TDMHSAS on legislation to increase the utility of the Controlled Substance Monitoring Database (CSMD). The Office of Prevention collaborates with TDH on a project that combines law enforcement data to the CSMD and overdose data. This project allows state departments and community partners to better identify and react to emerging and existing hotspots, as well as changes in the opioid crisis. Additionally, they have partnered with coalitions to delivery key prevention messages at physician training events across the state regarding how to safely prescribe opioids.

DSAS, in collaboration with the Department of Agriculture, addresses the issue of underage tobacco access through Synar. The Tennessee Department of Agriculture is responsible for coordinating and implementing the Synar survey. Tobacco compliance checks are completed statewide in establishments that sell tobacco products and are accessible to minors. Synar targets all youth under the age of 18.

DSAS continues its partnership with the National Guard, Counter Drug Task Force; Civil Operations Unit to provide well-trained and adaptable forces capable of developing anti-drug coalitions while implementing effective prevention practices.

While Tennessee's primary prevention system has several strengths, there are weaknesses. One key area of weakness is funding. The resources available do not allow for a comprehensive prevention system in all areas of the state. For instance, 46 of Tennessee's 95 counties have county level coalitions. Ideally, every county would have access to a funded coalition.

Through adherence to Culturally and Linguistically Appropriate Services (CLAS) Standards, TDMHSAS funded prevention programs are well-equipped to serve diverse communities:

a. Diverse cultural health beliefs and practices- As described above, the SPF process begins with assessment. This assessment will uncover the unique health beliefs and practices of the communities that receive TDMHSAS funding. The funded agencies then implement plans that are based on their knowledge of cultural health beliefs and practices for their respective communities.
b. Preferred languages- Again, as described above the SPF process allows for agencies to assess their communities and have a grasp on the specific languages that are unique to their area. TDMHSAS-funded providers understand that if they are truly going to make community-level change, it will be essential to reach people of all languages. Providers are encouraged to translate key informational materials or provide evidence-based programming into languages that are reflective of their community.

Inherent in the work of all TDMHSAS-funded providers is the importance of strategic partnership and collaborations with diverse groups that truly represent the population and needs in their respective communities. TDMHSAS continues to collaborate with community partners who understand that making change involves support and buy-in from all members of a community and work to make decisions that are built on collaboration and a spirit of win-win on a daily basis.

Early Identification

DUI Schools in Tennessee provide educational intervention services based on ASAM Level 0.5, Early Intervention, to individuals that are mandated by the court to receive this service or want to reinstate their driver's license privileges. Offenders receive an assessment, education and, if indicated, appropriate treatment referral. DUI Schools use the *Prime for Life* curriculum as the statewide standardized curriculum. *Prime for Life* curriculum is recognized by the National Registry of Evidence-Based Programs and Practices (NREPP) as a Promising Practice. The core focus is on improving attitudes of the student and creating a positive outlook to decrease dependency by using the latest research on brain chemistry and addiction.

Through the Tennessee ***Suicide Prevention Network***, substance abuse professionals are trained on evidence-based suicide prevention strategies to eliminate and reduce the incidence of suicide across the life span, reduce the stigma of seeking help associated with suicide, and educate communities throughout Tennessee about suicide prevention and intervention. SABG treatment counselors are required to participate in the training. The goals of the training are:

a. To reduce the incidence of suicide and suicide attempts.
b. To educate the general public about suicide prevention and intervention.
c. To reduce the stigma associated with mental illness and suicide.
d. To be a resource for information about suicide.
e. To educate mental health and substance abuse counselors and program administrators about the high incidence of mental health and substance abuse disorders and suicide attempts and suicide deaths.
f. To promote the use of evidence-based practices and guidelines for suicide prevention education and training.

DSAS received the Tennessee Opioid ***SBIRT*** (TOS) grant to provide opioid and other drug screening, brief intervention and referral to treatment services for individuals residing in East, Middle and West Tennessee. The overarching mission of this project is to reduce OUD and SUD across the state leading to reductions in alcohol and other drug misuse and associated consequences including overdose, health problems, and social and economic problems for persons suffering from these disorders.

Treatment Services

DSAS' Treatment structure has four service components to address the needs of individuals, communities and the State. This structure provides the framework and resources necessary to plan, develop, administer, and evaluate a statewide system of services for the treatment of persons whose use of alcohol and/or other drugs has resulted in patterns of abuse or dependence. Treatment Services' components included: provider network, recovery courts, emergency departments, coalitions and the TN RedLine. The ***provider network*** is the backbone of DSAS' treatment structure. They offer a full continuum of care based on the American Severity Index (ASI) screening tool and the American Society of Addiction Medicine (ASAM) Criteria to assess adults, pregnant women and women with dependent children; and the T-ASI and ASAM for adolescents. 98% of all treatment providers have been certified to provide Co-Occurring Disorder services. Utilizing state-funds, ***Recovery Courts*** provide treatment services on-site or refer individuals to DSAS-funded treatment agencies. Tennessee Recovery Navigators are people in long-term recovery who meet patients who have recently overdosed in the ***Emergency Department*** and connect them with treatment and recovery services. ***Coalitions*** work to provide marketing and community linkages to promote resources. The ***TN RedLine*** operates a twenty-four hours per day/seven days per week (24/7) toll-free telephone line (TN-Redline) to answer questions and give referrals to individuals seeking information relative to substance use and abuse prevention, treatment, and recovery as well as co-occurring disorders and problem gambling. Callers who would like to communicate directly with a treatment provider can receive a warm handoff or if they prefer to receive the information via text message, the RedLine has that capability. Other treatment services include: Medical Detoxification (state-funded); Medically Monitored Withdrawal Management; Tele-Treatment Program; HIV Community Outreach Engagement Prevention Program; Problem Gambling Outreach, Education, Referral and Treatment Program; Opioid Treatment Programs; and Medication Assisted Treatment.

DSAS' ***Pregnant Women and Women with Dependent Children (PWWDC)*** programs are rooted in the Recovery-Oriented System of Care model. PWWDC targets women and pregnant women with a substance use disorders or a co-occurring substance use and psychiatric disorder. Providers are required to publicize the availability of services. If a provider does not have capacity, they notify the State and the State assists with locating a treatment facility and/or ensure that interim services are provided until a facility is located. Services offered included but are not limited to: preference in admission to treatment; referral for primary medical care; childcare and prenatal care, including immunization; gender specific treatment and other therapeutic interventions for women; referral for therapeutic interventions for children in custody of women in treatment; case management; and transportation.

Due to the opioid epidemic, Tennessee has seen an increase in heroin treatment rates in the past five years. ***Injecting drug users (IVDUs)*** are a priority population for substance abuse treatment services and all block grant treatment providers are contractually required to give preference in admission. Other contractually required provisions of services for IVDUs included but are not limited to: notify the State upon reaching 90% capacity; admit an individual who request treatment no later than 14 days after request or within 120 days if treatment facility does not have capacity; notify the State to assist with placement if there isn't capacity; and provide interim services within 48 hours and continue to encourage injecting drug users to seek treatment.

Policies and procedures were developed in conjunction with the Tennessee Department of Health, Tuberculosis Elimination Program, to identify and prevent active ***Tuberculosis*** (TB) disease and TB infection (TBI) among employees, volunteers, and service recipients in alcohol and drug (A&D) treatment programs and prevention programs that offer direct services. All treatment providers are contractually required to meet the requirements of the ***Tuberculosis Control Guidelines for Alcohol and Drug Abuse Treatment Programs.*** DSAS has an agreement with all public health departments to provide TB testing for DSAS funded treatment agencies that do not have the capacity to perform the test. In addition, DSAS offers an on-line training course on the risk factors and symptoms of TB.

Identifying and enhancing services to populations who are vulnerable to disparities; and understanding differences in culture and the need to recognize and focus on those differences are an important part of the work for the DSAS' leadership and staff. Through the Tennessee Web-based Information Technology System (TN WITS), DSAS has the capability of tracking enrollment in services, type of services received, and outcomes based on demographics. Individuals can be identified by race, gender, ethnicity, and preferred language; therefore, giving us an overall picture as to who is seeking treatment and recovery support services in our substance abuse system. Individuals who have experienced violence, abuse, neglect, loss, disaster, war, and other emotionally harmful experiences are assessed utilizing a trauma screener and a treatment plan is developed that includes trauma specific services and referral for other community support services.

DSAS expects its partners to be or become proficient in the cultural needs of shared constituents through recruitment and retention of diverse staff, and through ongoing participation in focus groups, training, and planning activities. The provisions of services are clear and concise to ensure that service recipients receive services that are effective and efficient. Treatment agencies are required to provide services that are gender and culturally responsive. Recovery services are supported by a network of faith-based congregations and organizations that provide services and work as advocates to decrease stigma and support a common goal of strengthening individuals and families.

Recovery Services

Recovery Services promotes client engagement in the recovery process and provides services needed for support of continued recovery. Its structure has three service components to address the needs of individuals, communities and the State – provider network, faith-based congregations/organizations and lifeline peer coordinators. Approximately one hundred-five (105) faith-based and non-faith-based agencies provide recovery services through the ***provider network*** to keep individuals engaged in treatment or to provide continued recovery support. Services include transportation, transitional housing, health and wellness, employment skills and recovery activities. DSAS actively engage ***faith-based congregations/organizations*** as a means of increasing outreach, educational activities, access, and visibility to people seeking substance abuse services. ***Lifeline Peer Coordinators*** work to reduce stigma related to the disease of addiction, increase the number of recovery groups and meetings, and assist individuals in accessing treatment and/or recovery options in their community. Other recovery support programs are: Recovery Housing, Addiction Disorders Peer Recovery Support Centers and Peer Recovery Specialist Certification.

DSAS offers an application platform, ***TN Recover,*** for providers to share updates, clients to ask questions, support others, and stay connected throughout recovery through invite only. The app allows for peers and coaches to be able to share updates, ask questions, and offer support. It also allows individuals who have completed treatment or are in the process of completing treatment to receive inspirational messages,

updates for onsite events, and prompts to join a dialog around certain topics. There is also a recovery tracker where individuals can share their recovery date as well as a gratitude journal that they can keep private or share with others. The TN Recover app has been expanded to included ***primary prevention*** information for alcohol, tobacco, and prescription drugs/opioids; information on opioid overdose prevention, including information about available trainings on opioids and naloxone usage; and contact information for community substance use prevention coalitions and ROPS. It serves as a resource that individuals in the community, first responders, and community agencies access to connect with prevention information from across the state.

Treatment and recovery services are coordinated through the Tennessee Treatment and Recovery Advisory Council (TNTRAC). TNTRAC meets quarterly to provide guidance to the Division regarding programmatic (including the use of evidence-based practices), funding, and administrative decisions, as well as strategic planning. The Council is comprised of service providers and other stakeholders, as well as key Division staff. As needed, ad hoc committees are formed to address specific areas of concern/need. Each committee is co-chaired by members of TNTRAC with Division staff representation and 4 – 6 additional individuals representing provider agencies, advocates and consumers. There is a Women's Treatment and Recovery Committee and Adolescent Committee that meet at least annually or as often as needed. These committees are comprised of representatives from provider organizations as well as the State.

Criminal Justice

Criminal Justice is an integral part of our substance use disorder system. Its' structure has two service components to address the needs of individuals, communities, regions, and the State. This structure provides the framework and resources necessary to plan, develop, administer, and evaluate a statewide system of services for persons incarcerated or at-risk of incarceration due to the use of alcohol and/or other drugs. The criminal justice components are diversion programs and recovery courts. DSAS has worked persistently to increase the ***diversion programs*** offered to justice-involved individuals with substance use and mental health disorders. The Criminal Justice Behavioral Health Liaison Program works directly with the local jails and court system to facilitate access to service recipients with serious mental illness (SMI), mental illness (MI), co-occurring disorders (COD) or substance abuse disorders who come in contact with the criminal justice system due to incarceration or at risk of incarceration in order to determine what services are needed and what referrals are necessary to divert the service recipient from jail and the court system. Other diversion programs are: Alcohol and Drug Addiction Treatment (ADAT) for DUI offenders, Supervised Probation Offender Treatment program and Community Treatment Collaborative for at-risk probation and parole technical violators.

Recovery Courts are specialized courts or court calendars that incorporate intensive judicial supervision; treatment services; sanctions; and incentives to address the needs of non-violent justice-involved individuals with addiction and/or co-occurring mental health disorders. A recovery court team, composed of the judge; prosecutor; defense attorney; recovery court coordinator; probation officer; treatment providers; and other program staff, works in concert to ensure that defendants have the support of the justice system and treatment services to address their substance use issues and mental health needs. Drug Courts, Mental Health Courts, Veterans Treatment Courts, Family Treatment Courts, Juvenile Recovery Courts, DUI courts, and a Human Trafficking Court are all part of the recovery court umbrella.

The Recovery Court Advisory Committee works with TDMHSAS in reviewing program criteria, certification process and application, makes recommendations concerning implementation of programs and advises the Commissioner on the allocation of funds when funds are available. By law, the Recovery Court Advisory Committee is made up of the following representatives: two (2) judges who are currently

presiding or have presided over a recovery court program for at least 2 years; two (2) recovery court coordinators who have functioned as a drug court coordinator in actively implemented recovery courts for at least 2 years; and at least two (2) additional members representing recovery court stakeholders (treatment/recovery support providers, court administrator, etc.). Staggered terms with initial appointments are established by the Commissioner. A member serves a four-year term and a member may be appointed to serve one additional consecutive term. Each member appointed represents a different region in the state (East, Middle and West).

The Criminal Justice System serves a very diverse population. Effectively communicating with justice-involved individuals is essential to providing successful behavioral health care coordination. Recovery courts in the State of Tennessee are required to have policies addressing their processes for engaging diverse populations. Programs are tasked with ensuring that they are appropriately addressing the needs of minority groups, including racial, ethnic, and sexual gender minorities. Assessment tools are provided for recovery courts to utilize to gauge their effectiveness in this area, and DSAS provides technical assistance for the process.

Identify the unmet service needs and critical gaps within the current system.

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) *Statewide Needs Assessment of Substance Abuse Services* (May 2021) provides an in-depth review of the prevention, treatment, recovery, and criminal justice portions of the system. The needs assessment specifically sought to understand the system in three key areas: access, quality, and workforce.

- **Access** was defined as the ability of persons to receive prevention, treatment, and recovery services.
- **Quality** was defined as having the necessary mechanisms in place to provide effective services.
- **Workforce** was defined as the persons who are employed by contracted agencies to provide publicly funded substance abuse services.

The mixed-method data collection approach was used for the needs assessment with a variety of quantitative and qualitative data sources considered for inclusion. Quantitative Data Sources included the Tennessee Web-based Information Technology System, National Survey on Drug Use and Health and American Community Survey. Qualitative Data was collected using a combination of in person and virtual site visits to address current existing data gaps and collect qualitative data from multiple perspectives on access, quality assurance, and workforce from the different points on the continuum. Five Regional Focus Groups were conducted in each of the seven planning regions of the state.

According to the NSDUH, during 2019, approximately 356,000 Tennesseans 12 and older needed but did not receive treatment for an SUD.[2] Access to effective treatments for SUDs is a critical public health issue. Difficulties in access to care may account for the large proportion of individuals with alcohol and/or substance use disorders who do not receive any care for their disorder and the low proportion who engage in or acheive sustained involvement with treatment.[3]

In an effort to explore these issues, quantitative and qualitative data were obtained from the prevention, treatment, recovery, and criminal justice programs through service data, a survey, and focus groups.

The State Epidemiological and Outcomes Workgroup (SEOW) provides feedback and observations on various data reports for state departments and agencies. Tennessee's SEOW is composed of representatives of the Tennessee Department of Mental Health and Substance Abuse Services, the Tennessee Bureau of Investigation, the Tennessee Department of Health, the Tennessee Department of Safety and Homeland Security, the Tennessee Department of Correction, the Tennessee Department of Military, the Tennessee Division of Health Care Finance and Administration, the Tennessee Department of Children's Services, the Tennessee Department of Education, East Tennessee State University, and Oasis Center, Inc. The SEOW profiled and prioritized population need, resources, service gaps and readiness capacity. They provide guidance and feedback to the comprehensive strategic planning process at the state and community levels; and made data-informed observations.

Substance use disorder services are important because those disorders produce serious consequences for individuals, families and society. Need is not determined simply by substance use or abuse, but by those behavior patterns (i.e., disorders) that are highly associated with negative consequences, and by those populations that are most likely to exhibit these patterns of behavior and remain underserved or unserved. Data concerning the incidence and prevalence of use in a population becomes much more useful if there is a focus on those indicators that are most highly associated with the negative consequences that are the cause for concern. Data on problems is also more useful if it provides guidance on who is most likely to experience these problem behaviors, and how they can be identified for outreach and improved service access.

SABG Priority Populations

Female Substance Abuse – Pregnant Women and Women with Dependent Children (PWWDC)
Through an agreement with seventeen (17) non-profit providers, Tennessee ensures that PWWDC who seek or is referred for treatment receive the following services:

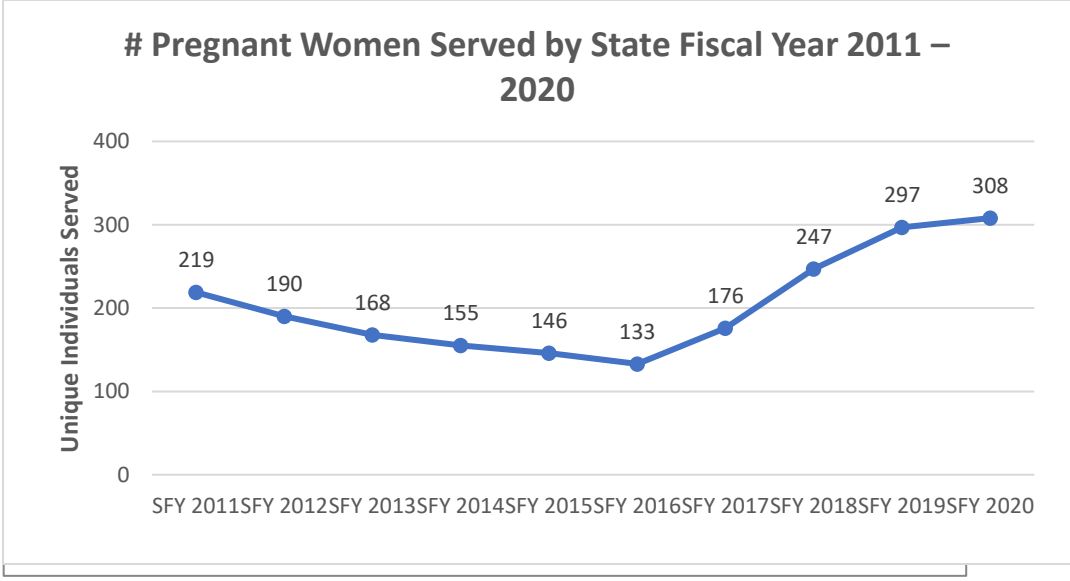
- Preference in admission to treatment
- Referral for primary medical care
- Childcare and prenatal care; including immunization
- Gender specific treatment and other therapeutic interventions for women

[2] SAMHSA, Center for Behavioral Health and Quality, National Survey on Drug Use and Health, 2018 and 2019.
[3] Fortney, J., & Booth, B.M. (2002). Access to Substance Abuse Services in Rural Areas. In: *Alcoholism. Recent Developments in Alcoholism (Services Research in the Era of Managed Care)*, vol 15. Springer. https://doi.org/10.1007/978-0-306-47193-3_10

- Referral for therapeutic interventions for children in custody of women in treatment
- Case management
- Transportation

Providers are required to publicize the availability of services for PWWDC. If the provider does not have capacity, they notify the State and the State assist with locating a treatment facility and/or ensure that interim services are provided until a facility is located.

Although comprehensive services are offered for PWWDC and enrollment numbers have more than doubled since SFY16, the percentage of discharges due to success (e.g., no further care needed, treatment completed) or neutral reasons (e.g., participant moved) have decreased in the past few years, while the percentage of unsuccessful discharges (e.g., treatment not completed) increased. The most common reason for unsuccessful discharge in this population consistently has been that the treatment provider lost contact with the patient and/or the patient left against medical advice. Though TDMHSAS has had great success in increasing enrollment numbers, serving 308 pregnant women in SFY 2020 compared to 133 in SFY 2016, retaining this population in treatment has been a challenge.



2020 was a pivotal year for Tennessee as it relates to overdose deaths and other causal factors related to the Covid-19 pandemic with a record 3,032 overdose deaths, a 45% increase from 2019. Fentanyl and stimulants continue to be major contributors to this increase. There were 2,388 overdose deaths associated with all opioids and its's estimated that 35% of those individuals were women. The growth of the opioid crisis further complicates DSAS treatment efforts for this population because it has led to more intense treatment needs. An analysis of DSAS services for pregnant women in SFY20 revealed that more than twice as many women whose treatment was successful had received recovery services such as childcare and recovery housing (69% having received recovery services vs. 31% who did not).

Individuals with a Diagnosis of Opioid or Heroin Use Disorders – Injecting Drug Users

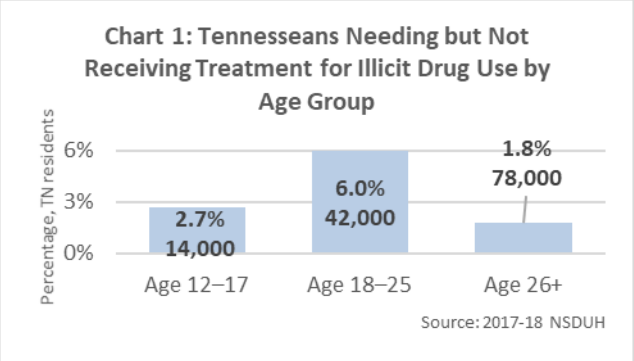
The opioid use disorder (OUD) epidemic is a national problem that requires partnerships among federal, state, and local organizations to address prevention, treatment and recovery services. According to reports from the Centers for Disease Control (CDC), drug overdose deaths in the United States rose 32.2%, from 2015 (52,623) to 2019 (70,630). Opioids were involved in 49,860 overdose deaths in 2019 (70.6% of all drug overdose deaths). While the percentage has increased nationally the percentage of drug overdose

deaths involving opioids has risen in Tennessee along with the overall drug overdose death rate. In 2013, 64.7% of the 1,166 drug overdose deaths involved opioids; 2020, 79% of overdose deaths involved opioids.[4] Of the 21,799 unduplicated individuals DSAS served in SFY 20, 52.9% (11,526) had an opioid as a substance of use.

Deaths involving any stimulants have consistently increased over the past five years: a 218% increase from 2016 to 2020. Deaths involving stimulants other than cocaine, a category that includes primarily deaths involving methamphetamine, have increased substantially over this period. Deaths involving both opioids and stimulants have also increased over the past five years, and in 2020, 73% of stimulant involved deaths also involved an opioid.

TN data from the National Survey on Drug Use and Health (NSDUH 2017-2018)[3] reveals that in the past year 6.8% of 18-25 year-olds (est. 47,000) and 3.4% 26+ year-olds (est. 151,000) used pain relievers for non-medical purposes. Although the Tennessee rate of past-year opioid use disorder is 19.4% higher than that of the U.S. overall (.74% in TN vs. .62% in U.S.), Tennessee residents are 50% less likely to receive medication-assisted treatment than the U.S. overall (58/100,000 population in TN vs. 115 in the U.S.). These use rates and the consequences associated with them are devastating to individuals, families, communities, regions and to the State of Tennessee and must be addressed.

Chart 1.
Tennesseans Needing but Not Receiving Treatment for Illicit Drug Use by Age Group



The 2020 National Survey of Substance Abuse Treatment Services (N-SSATS) report indicates that Tennesseans are unlikely to be in treatment compared to other states. Tennessee's rate of 323 individuals in treatment per 100,000 population 18 and older compares to the U.S. rate of 390, meaning U.S. residents overall are 20.7% more likely to seek treatment. Chart 1 compares the percentages of Tennesseans who needed treatment for illicit drug use but did not receive it across age categories, based on 2017–18 annual averages. Tennessee performs on average in providing treatment services for illicit drug use when compared to other states, and the state rate of individuals who need but don't receive treatment for illicit drug use is similar to that of the nation overall (2.35% in TN bs. 2.55% in the U.S.). However, the rate of 12- to 17-year olds who needed but did not receive treatment in the previous year (2.69%) is 52% higher than the same rate among Tennesseans ages 26 and older (1.77%), indicating that more outreach to adolescents is crucial to preventing the long-term effects of illicit drug use in the future.

The OUD issue in Tennessee is statewide but depending upon the type of opioid the use pattern can differ greatly. Data for heroin related indicators shows greater rates in the urban areas and moving to suburban areas, while prescription opioid related indicators show greater rates in rural areas of the state.

[4] Tennessee Department of Health (2021). Tennessee Drug Overdose Data Dashboard.

All block grant treatment providers are required to treat individuals who inject drugs. They are contractually required to do the following:

- Notify the State upon reaching 90% capacity to admit individuals in its programs
- Admit an individual who request treatment no later than 14 days after request or within 120 days after request has been made if the treatment facility does not have capacity
- If there isn't capacity to admit the individual, notify the State to assist with placement
- Provide interim services within 48 hours and continue to encourage injecting drug users to seek treatment

In SFY 2022 and 2023, DSAS plans to continue increasing access to MAT by adding long- acting buprenorphine (Sublocade) as well as naltrexone for individuals with alcohol use disorder.

Individuals at Risk for Tuberculosis

Through consultation with the Tennessee Department of Health, Tuberculosis Elimination Program, DSAS developed policies and procedures to identify and prevent active tuberculosis (TB) disease and TB infection (TBI) among employees, volunteers, and service recipients in alcohol and drug (A&D) treatment programs and prevention programs that offer direct services. All treatment providers are contractually required to meet the requirements of the ***Tuberculosis Control Guidelines for Alcohol and Drug Abuse Treatment Programs.*** Requirements for TB screening and testing include:

- Testing and medical evaluation to determine the presence or absence of active TB disease or TBI in employees and volunteers of alcohol and drug treatment programs and recipients of alcohol and drug treatment services must conform to current guidelines of the Tuberculosis Elimination Program of the Tennessee Department of Health.
- A&D treatment facilities must provide baseline screening of all new employees and new volunteers for symptoms of active TB disease and appropriate testing for TBI prior to employment or provision of volunteer services.
- A&D treatment facilities must ensure that all employees and volunteers who provide direct care services are screened annually for symptoms of active TB disease and appropriately tested for TBI.
- A&D treatment facilities must counsel all employees and volunteers annually regarding the symptoms and signs of active TB disease.
- Any A&D treatment program employee or volunteer with symptoms suggestive of active TB disease must be referred immediately for appropriate medical evaluation and cleared by a licensed medical provider prior to return to work in the facility or provision of direct care services.
- Any A&D treatment program employee or volunteer reported by a health care provider to the health department as having suspected or confirmed active TB disease must be excluded from the facility and from provision of direct care services until the employee or volunteer is determined to be non-infectious by the local health department.
- All A&D treatment facilities must screen all prospective service recipients for symptoms suggestive of active TB disease prior to each admission for A&D treatment services.

- Prospective service recipients presenting with symptoms suggestive of active TB disease must be referred immediately for appropriate medical evaluation and cleared by a licensed medical provider prior to admission for A&D treatment services.
- Any service recipient reported by a health care provider to the health department as having suspected or confirmed active TB disease must be excluded from services until the service recipient is determined to be non-infectious by the local health department.
- Prospective recipients of all A&D treatment services who present without symptoms of active TB, and have no documentation of a previous positive TB test and have no documentation of testing for TBI within the past six (6) months must be appropriately tested for TBI within five (5) business days of initiation of A&D treatment services. The exceptions for testing are Outpatient ASAM Levels 1, 2.1 and 2.5; however, all service recipients must be screened for symptoms of active TB disease.
- A&D treatment facilities must counsel all service recipients about the symptoms and signs of active TB disease during each admission for A&D treatment services.
- All A&D treatment facilities must provide case management activities to ensure that employees, volunteers, and service recipients diagnosed with TBI receive appropriate medical evaluation, counseling about the risk of TBI progressing to active TB disease, and TBI treatment if such treatment is recommended to and accepted by the employee, volunteer, or service recipient.
- Testing for TBI may be conducted by qualified medical personnel at an A&D treatment facility or by referral to a licensed medical provider.
- All TB screening and testing records of employees, volunteers, and service recipients are considered personal medical information protected by HIPAA and must be archived accordingly.

DSAS has an agreement with all public health departments to provide testing for DSAS funded treatment agencies that do not have the capacity to perform the TB test. Individuals present DSAS' screening tool to the health department and gives consent to communicate the test results to the treatment agency.

To increase provider's knowledge about the risk factors and symptoms of TB, DSAS provides an on-line training course and examination. When the individual passes the exam, a certificate is provided acknowledging their success. In SFY 2022 and 2023, DSAS intends to continue offering the on-line training course and training at substance abuse treatment facilities.

Individuals in Need of Primary Substance Abuse Prevention

The Office of Prevention continues utilize the TN Together Student survey, SEOW, and DSAS SEOW analysis to identify gaps in services, unmet needs, and potential new target populations.

The 2018-2019 Tennessee Together Student Survey captured data on substance use attitudes and behaviors among Tennessee public eighth-, 10th-, and 12th-grade students. The final survey sample included more than 21,000 respondents from five Behavioral Health Planning Regions, 28 counties, and more than 150 schools statewide.

The Tennessee Together Student Survey represents the largest survey of youth alcohol and other drug use ever undertaken in the state. Previously, TDMHSAS - DSAS had been reliant on federal estimates for data on a state or regional level, which would create a local level data gap. Data gathered by the TN Together

survey used in conjunction with federal data will allow for a more complete picture of needs and substance use trends among youth in 8th - 12th grades. It fills a critical information gap by providing locally representative data that has been previously unavailable for most Tennessee counties or regions. The addition of local data will allow for more targeted efforts on substance use prevention by prevention providers in the state.

The comprehensive state report represents the culmination of this survey effort. The report presents aggregated weighted data on alcohol, tobacco, and other drug use among 8th-, 10th-, and 12th-grade students. The report includes data comparisons across demographic subgroups and Behavioral Health Planning Regions. The 2018-19 survey is the first in a series of biennial administrations that will be used to monitor trends in substance use behaviors and attitudes over time; identify emerging alcohol, tobacco, and drug use patterns; and inform state and local prevention planning and evaluation efforts to reduce substance use and related consequences throughout the state of Tennessee.

The Tennessee Together Student Survey measurement tool comprises 24 core questions and 70 sub-questions, covering each of the following constructs:

- Lifetime and past 30-day alcohol, tobacco (including e-cigarettes), illicit drug, and prescription drug misuse;
- Age of onset of alcohol, tobacco, marijuana, and prescription drug misuse;
- Ease of access to alcohol, tobacco, marijuana, and prescription drugs, and methods of obtaining alcohol or prescription drugs;
- Peer substance use;
- Riding in a car with someone under the influence of alcohol or prescription drugs;
- Personal, peer, and parental approval of alcohol, tobacco, marijuana, and prescription drug misuse;
- Perceived risk of alcohol, tobacco, marijuana, and prescription drug misuse;
- Family communication about tobacco, alcohol, illicit drug, and prescription drug misuse; and
- Exposure to prevention messaging regarding the dangers of prescription drug misuse.

In 2020, Tennessee was ranked 44th of 50 U.S. states and the District of Colombia by the United Health Foundation on measures of overall health[5]. Tennessee ranked poorly on measures of premature death (potentially due to an increase in opioid related overdoses), chronic health concerns, such as heart disease and diabetes, and a high prevalence of smoking. Although Tennessee was ranked sixth lowest in the nation on measures of binge drinking and excessive alcohol use, indicating low overall prevalence of alcohol-related problems, this was in improvement from the second lowest ranking on this measure in 2015. Additionally, the state was ranked 38th out of 50 states on measures of drug-related deaths, highlighting the serious health consequences of drug misuse and abuse.

While there has been progress made in decreasing the nonmedical pain reliever use prevalence from among young adults (18 – 25 years old) from 8.33% in 2014 to 5.20% in 2019 (NSDUH), as mentioned previously, the number of overdoses in Tennessee has steadily been on the rise showing that there is additional work to be done in this area. As reported by Tennessee Department of Health, in 2020, Tennessee recorded 3,032 overdose deaths, a 45% increase from 2019. Fentanyl and stimulants continue to be major contributors to this increase. Positive indicators that show the primary prevention work across the state is having an impact include: In 2020, we saw a decrease of 20% from 739 pain reliever related

[5] United Health Foundation. 2020 America's Health Rankings Annual Report. Accessed from https://www.americashealthrankings.org/explore/annual/measure/Overall/state/TN

overdoses in 2016 to 595 in 2020; as recorded by the controlled substance monitoring database, the amount of morphine milligram equivalents (MMEs) dispensed has decreased by 57.03% (2012-2020); and the number of opioid prescriptions for pain has reduced by 43% (2012-2020). With block and other discretionary (SPF, COVID, and ARPA) grant funding TDMHSAS prevention providers will address prescription drug misuse in their communities through implementation of data-based plans that include environmental, community, and individual based strategies.

The Tennessee population is also diverse, with numerous subgroups defined based on characteristics that place them at elevated risk for experiencing alcohol and drug disorders. These populations of focus include, but are not limited to, youth and young adults, seniors and older adults, active military and military veterans, lesbian, gay, bisexual, or transgender (LBGTQ+) populations, rural and homeless populations, and people who are disabled. For example, young adults 18–25 years of age, who account for about 9 percent of the total state population, often experience substantially higher rates of alcohol and prescription drug misuse than the general population as they transition between youth and adulthood. Rural populations, which account for about 30 percent of the state population, also experience high relative rates of substance use disorders, influenced by factors such as lower educational attainment, unemployment, and poverty. Rural areas also have more limited access to resources addressing alcohol and drug prevention, treatment, and recovery needs. LBGTQ+ populations are also at heightened risk for disparities and have been historically under-represented and underserved in mainstream prevention planning efforts. Research studies estimate that as many as 20–30 percent of gay and transgender people abuse substances, compared to 9 percent of the general population (Center for American Progress, 2012).

The difficulty of obtaining estimates of alcohol and other drug prevention need within these sub-populations and communities presents an ongoing data challenge is a critical gap within the prevention system. For this reason, an important focus of continuing work will be to enhance data system capacity to determine where subpopulations are concentrated and to better document sub-population needs, to inform state level prevention planning efforts, and ensure that resources are allocated to regions and communities where priority needs are greatest. Other gaps include lack of funding for prevention services and statewide coalition coverage.

In 2016 DSAS applied for and received the Strategic Prevention Framework for Prescription drug (SPR Rx) grant. The SPF-Rx grant was granted to the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) in fiscal year 2017. The overarching purpose of this project is to reduce opioid use and overdose among Tennesseans. Specifically, to reduce opioid use among Tennesseans 12 – 25 years old by 25%, reduce prescription drug related car crashes and injuries by 5%, reduce prescription drug related crime by 4%, reduce prescription drug related emergency room visits by 4%, reduce the number of babies born in TN with Neonatal Abstinence Syndrome by 5%, and reduce the number of overdose deaths by 4%. SPF-Rx concentrates on counties that both have high levels of opioid morphine milligram equivalents (MMEs) dispensed and reported to the CSMD (Controlled Substance Monitoring Database, Tennessee's Prescription Drug Monitoring Program) as well as a current state-funded coalition that do not currently receive PFS-Rx funding. Grantees are working on several strategies to impact the following goals: Incorporate CSMD data into TDMHSAS practices, implement a public education plan throughout the counties, strengthen prevention capacity and infrastructure at the State and community level in support of prevention, and reduce the non-medical use of prescription drugs among Tennesseans of all ages by 25%. Some of the current strategies coalitions are implementing are: town hall meetings and medical forums within their counties, the distribution of lock boxes, education on proper storage practices, education on proper prescribing practices, education on the proper use of the CSMD, trainings within their community using the SAMHSA overdose prevention toolkit, collaboration with Regional Overdose Prevention Specialists to educate on opioid overdose prevention and Naloxone training, as well as mentoring other

communities within their regions to expand prevention capacity. These coalitions have already been very successful in many of these areas within their communities and look to do more in the remaining years of this grant.

In addition, DSAS is working closely with the Evidence-Based Practice Workgroup (EBPW) operationalized the definition of Evidence Based Practice (EBP) in TN to assist coalitions in determining the viability of proposed interventions through a rigorous review process. The purpose of EBPWs is to (1) understand the State's Partnership for Success/ Block Grant prevention priorities and logic models; (2) identify and select evidence-based interventions; and (3) review and make recommendations on communities' comprehensive plans. Utilizing this resource enhances services of the states limited resources responsibly.

An extensive needs assessment to better understand the current publicly funded Tennessee substance abuse system was done in 2020-2021. The three areas of focus for the Prevention portion were: Access, Quality, and Workforce.

Access:
A total of 40,016 persons were served with individual-based programs and strategies. Half of persons served (50.0%) were male, most were 18 or older (75.6%), and most identified as White (82.9%). Racial and ethnic minority populations (except for American Indian and Alaska Native and Native Hawaiian and Other Pacific Islander) are underrepresented in the population served through individual-based prevention programs.

Stigma associated with substance use disorders was a key barrier to accessing prevention services. Prevention programs and coalitions often lack funding and resources. Services are not consistently offered throughout the state, as many counties do not have a coalition or offer individual-based programs.

Prevention programs and coalitions are most effective at engaging with the community when they have built solid partnerships and are trusted sources of information. In addition, coalitions have taken an important role in reducing opioid deaths by distributing Narcan (naloxone), and individual-based programs have effectively reached out to high-risk populations. In SFY 2022 and 2023, TDMHSAS plans to leverage federal and discretionary grant dollars to increase the number of coalitions and counites that can access individual-based primary prevention programming. Also, in an effort to reach hard to access counties a virtual mentoring platform/app that provides awareness around alcohol, opioids, stimulants, and other substances is being developed in partnership with a current TDMHSAS primary prevention provider.

Quality:
Over 89% of agencies surveyed use EBPs to provide prevention services, including 100% of agencies providing Tennessee Prevention Network services, 88% of agencies providing coalition services, and 84% of agencies providing Regional Overdose Prevention Services (ROPS) services. Approximately 39% of all agencies reported using Mental Health First Aid, with over 43% of coalitions and over 52% of agencies that provide ROPS using this strategy. Key barriers to quality EBP implementation included difficulty implementing EBPs with fidelity due to various constraints, including difficulty implementing in school settings with the dosage and duration that are required and difficulty implementing environmental strategies.

There is a lack of funding available from the state for EBP trainings and related conferences. In addition, there is a lack of training specific to EBPs. Many EBPs are copyrighted and expensive to implement. Agencies and coalitions would like to be able to train their staff on EBPs, but the curriculum, training, and ongoing coaching can be cost prohibitive. Other barriers to training include the lack of local trainings and

taking staff away from their normal work to engage in training. Many agencies mentioned that the increase in online and virtual training has helped defray costs and lost staff time.

All surveyed prevention programs agreed that there are mechanisms in place to determine the effectiveness of services being provided. In addition, over 59% of agencies noted their agency uses strategies to support QA and continuous quality improvement (CQI) for delivery of prevention services. One large barrier to measuring the effectiveness of prevention activities is the difficulty of measuring something that does not occur (i.e., something that you prevented). In addition, respondents felt that when change does occur, specifically at the community level, it is hard to attribute that change solely to prevention work. Other barriers that were discussed included the high cost of evaluation activities. Preventionists reported that having timely opioid overdose data available was helpful for responding quickly to emerging problems. In addition, agencies reported the importance of adopting programs with built-in fidelity and evaluation instruments.

To address quality concerns, in SFY 2022 and 2023, TDMHSAS will continue to provide training through the National Coalition Academy to Substance Use Prevention Coalitions. The Academy is a comprehensive training program developed by CADCA's National Coalition Institute that teaches leaders "what they need to know" (the core competencies) and "what their team needs to do" (the essential processes) to establish and/or maintain a highly effective substance use prevention coalition. In an effort to address concerns around accessing and providing EPBs with fidelity to the model, TDMHSAS identified 3 individual-based EBPs to offer TDMHSAS supported training and materials to TDMHSAS-funded providers.

The three EBPS are:

- The Strengthening Families Program an evidence-based family skills training program for high-risk and general population families that is recognized both nationally and internationally. Parents and youth attend weekly SFP skills classes together, learning parenting skills and youth life and refusal skills.
- Positive Action is based on the intuitive philosophy that we feel good about ourselves when we do positive actions. The Thoughts-Actions-Feelings Circle (TAF) illustrates how this works in life: our thoughts lead to actions and those actions lead to feelings about ourselves which in turn lead to more thoughts.
- LifeSkills Training (LST) is a three-year universal prevention program for middle/junior high school students targeting the use of gateway substances (tobacco, alcohol, and marijuana) and violence. The program provides students with training in personal self-management, social skills, and social resistance skills

By providing access at the state level to these RPBs the goal is to lessen the burden on providers while creating an environment where they can access materials and training from the state on an as needed basis.

Workforce:

The prevention workforce is largely female, White non-Hispanic, and between the 25 and 44. Most have a higher education degree, either bachelor's or master's, and have worked at their agency for 5 years or longer. Over half of the workforce has an annual income of $30,000 to $49,000.

While 21% of agency leaders noted that recruiting staff was difficult or very difficult, 41% said it was easy. Almost 40% of agency leaders were neutral about the difficulty of recruiting prevention staff. Respondents reported that it was difficult to capture the complexities of prevention work in a job description. Agencies

reported that networking with other prevention agencies and being able to offer licensure facilitated recruitment.

While 24% of agency leaders noted that retaining qualified staff for their agency was difficult, 42% reported it was easy or very easy, and 33% felt neutral about the difficulty of retaining staff. Despite these obstacles, retention is bolstered by people's commitment to do the work that they see as meaningful.

To meet any of the aforementioned gaps, TDMHSAS will need to equip the Prevention workforce with the tools that they need to be successful to provide services to Tennesseans in need. Through continually assessing the Prevention workforce for training needs and preferred methods of delivery, TDMHSAS will be able to identify trainings that can be delivered which will provide the most value. A survey of prevention providers in FY 2021 identified some of the training gaps/ opportunities to include: methods on conducting proper environmental/ community scans; RBS training; how to conduct a proper Drug Take Back Day; the need for Substance Abuse Prevention Skills Training; and annual Prevention Ethics training. While not an exhaustive list, providers will receive on-line and regional face-to-face educational and training opportunities on topics of interest to them to help increase the knowledge of evidence-based programs and strategies for the prevention.

In SFY 2022 and 2023, to close data gaps, DSAS intends to utilize recurring funds as needed to expand the TN Together Survey to expand counties beyond the 28 initially surveyed. Also, DSAS will continue to collaborate with the Tennessee Department of Health, SEOW partners, and other departments to identify data resources that can be used by community partners.

Prioritize State Planning Activities

Using the information in Step 2 (Identify the unmet service needs and critical gaps within the current system), states should identify specific priorities that will be included in the MHBG and SABG. The priorities must include the core federal goals and aims of the MHBG and SABG programs: target populations (those that are required in legislation and regulation for each block grant) and other priority populations described in this document. States should list the priorities for the plan in Plan Table 1 and indicate the priority type (i.e., substance use disorder prevention (SAP), substance use disorder treatment (SAT), or mental health services (MHS).
Step 4: Develop goals, objectives, performance indicators, and strategies
For each of the priorities identified in Step 3, states should identify the relevant goals, measureable objectives, and at least one-performance indicator for each objective for the next two years.

For each objective, the state should describe the specific strategy that will be used to achieve the objective. These strategies may include developing and implementing various service-specific changes to address the needs of specific populations, substance abuse prevention activities, and system improvements that will address the objective.

Priority 1

Priority Area: Prevention

Priority Type: Substance Abuse Prevention (SAP)

Population: Primary Prevention (PP)

Goal: Decrease non-medical use of pain relievers for young adults, age 12-25

Objective: Reduce prescription drug misuse and abuse among youth age 12-25

Strategy: Substance Abuse Prevention Coalitions will address prescription drug misuse in their communities through implementation of data-based plans that include environmental and community-based strategies.

Indicator: Percentage of young adults, ages 18-25, who report using pain relievers for non-medical use in the past year

Baseline Measurement: 5.2%

1st yr target/ outcome: 5.2%

2nd yr target/ outcome: 5.2%
Maintain baseline

Data Source: National Survey on Drug Use and Health prevalence estimates on Pain Reliever Misuse in the Past Year for Tennessee

Description of Data: Conducted by the federal government since 1971, the survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.

Data issues/ caveats that affect outcome: No issues are currently foreseen that will affect the outcome measure

Priority 2

Priority Area: Persons Who Inject Drugs (PWID)

Priority Type: Substance Abuse Treatment (SAT)

Population: PWID

Goal: All contracted providers will provide treatment services to individuals who inject drugs

Objective: To increase the availability of Medication-Assisted Treatment (MAT) Services in the community

Strategy: Ensure individuals who inject drugs and have an Opioid Use Disorder (OUD) have access to MAT services

Indicator: Percentage of individuals who disclose they inject drugs and receive MAT services

Baseline Measurement: 45.3%

1st yr target/ Outcome: 35%

2nd yr target/ Outcome: 36%

Data Source: Tennessee Web-based Information Technology System (TN-WITS)

Description Of Data: Clients who identify their route of administration as "injection" and receive services

Data issues/ caveats that affect outcome: Potential budget reductions and route of administration

Priority 3

Priority Area: Pregnant Women and Women with Dependent Children (PWWDC)

Priority Type: Substance Abuse Treatment (SAT)

Population: PWWDC

Goal: Access to quality Substance Use Disorder (SUD) treatment for pregnant women and women with dependent children with an Opioid Use Disorder (OUD)

Objective: Increased access to SUD treatment for pregnant women and women with dependent children with an OUD

Strategy: Provide training and technical assistance to SUD treatment providers on opioid and other substance use during pregnancy, access to gender-related responsive services, and other related information.

Indicator: Increase number of PWWDC with OUD accessing SUD treatment

Baseline Measurement: 1,702

1st yr target/
Outcome: 1,200
2nd yr target/
Outcome: 1,224

Data Source: Tennessee Web-based Information Technology System (TN-WITS)
Description of Data: Individuals who identify opioids as a substance of use at intake and having at least one dependent child

Data issues/ caveats that affect outcome: Potential funding reduction

Priority 4

Priority Area: Medication-Assisted Treatment (MAT) Services

Priority Type: Substance Abuse Treatment (SAT)

Population: Other - MAT

Goal: Increase the number of individuals receiving MAT for Opioid Use Disorder (OUD)

Objective: Increasing number of individuals receiving MAT for OUD

Strategy: Provide MAT services (methadone, naltrexone, and buprenorphine) for individuals with OUD

Indicator: Number of individuals receiving MAT services

Baseline Measurement: 5,318

1st yr target/
Outcome: 4,500

2nd yr target/
Outcome: 4,500

Data Source: Tennessee Web-based Information Technology System (TN-WITS)

Description Of Data: Individuals with a group enrollment or service of MAT

Data issues/ caveats that affect outcome: Reduction in funding

Priority 5

Priority Area: Tuberculosis (TB)

Priority Type: Substance Abuse Treatment (SAT)

Population: Early Intervention Services (EIS) HIV

Goal: Increase the number of individuals who receive training on TB

Objective: To address needs of individuals with or at risk of contracting TB

Strategy: Make available programs that provide education and training on TB

Indicator: Number of individuals trained

Baseline Measurement: 16,000

1st yr target/ Outcome: 16,200

2nd yr target/ Outcome: 16,500

Data Source: Tennessee Web-based Information Technology System (TN-WITS)

Description Of Data: The number of individuals who attend and receive services through HIV/ EIS/ TB/ HCV outreach

Data issues/ caveats that Affect outcome: Not having a status as a designated state

Priority 6

Priority Area: Criminal Justice

Priority Type: Substance Abuse Treatment (SAT)

Population: Other – Criminal Justice

Goal: Ensure women who are eligible for the Women's Residential Recovery Court program have the opportunity to participate

Objective: Link substance abuse and co-occurring treatment services that are culturally responsive to individuals involved in the Women's Residential Recovery Court program

Strategy: Increase number of women accessing the Women's Residential Recovery Court program

Indicator: Number of women enrolled

Baseline Measurement: Baseline

1st yr target/ Outcome: Baseline

2nd yr target/ Outcome: Baseline

Data Source: Tennessee Web-based Information Technology System (TN-WITS)

Description Of Data: Number of women enrolled in the program

Data issues/ caveats that Affect outcome: COVID

Priority 7

Priority Area: Workforce Development

Priority Type: Substance Abuse Prevention (SAP)

Population: Other – Prevention, Treatment and Recovery Support Workforce

Goal: Increase the knowledge of evidence-based programs and strategies for the prevention, treatment, and recovery support workforce

Objective: Enhance professional growth of the substance abuse prevention, treatment and recovery support workforce

Strategy: Provide on-line and regional face-to-face educational and training opportunities for prevention, treatment and recovery support professionals

Indicator: Number of substance abuse professionals receiving training on prevention, treatment, and recovery support services

Baseline Measurement: 3,196 persons

1st yr target/ Outcome: 3,100 persons

2nd yr target/ Outcome: 3,100 persons

Data Source: Attendance sheets of training classes, on-line training records

Description Of Data: Attendance sheets are maintained during training courses and are used to determine the number of individuals that attended training. Additionally, online training is tracked through a report generated from the on-line systems

Data issues/ caveats that affect outcome: Virtual vs. In-Person training

Priority 8

Priority Area: Recovery Support

Priority Type: Substance Abuse Treatment (SAT)

Population: Other – Persons in need of recovery support services

Goal: Provide recovery services that promote long-term recovery

Objective: Provide culturally responsive opportunities for individuals to access recovery support services

Strategy: Provide an array of adult and adolescent recovery services to increase their chances of long-term recovery

Indicator: Number of individuals enrolled in recovery support services

Baseline Measurement: 12,515 individuals

1st yr target/ Outcome: 12,000 individuals

2nd yr target/ Outcome: 12,000 individuals

Data Source: Tennessee Web-based Information Technology System (TN-WITS); TN Recover App

Description Of Data: Individuals who receive recovery support services

Data issues/ caveats that Affect outcome: COVID

Priority 9

Priority Area: Trauma

Priority Type: Substance Abuse Treatment (SAT)

Population: Other: Individuals who have experienced trauma

Goal: Treatment agencies will provide assurance that individuals who have experienced trauma are receiving trauma informed care services

Objective: Address the needs of individuals who have experienced trauma

Strategy: Provide trauma informed care services to individuals who have disclosed experience with trauma

Indicator: Number of individuals who have been screened for trauma

Baseline Measurement: 13,103
1st yr target/ Outcome: 13,000
2nd yr target/ Outcome: 13,000

Data Source: Tennessee Web-based Information Technology System (TN-WITS)

Description Of Data: Individuals who, during the intake process, responded "yes" to Violence or Trauma

Data issues/ caveats that Affect outcome: COVID

Priority 10:
Priority Area: Recovery Housing

Priority Type: SAT

Population: Other: Homeless

Goal: Expand self-supporting and drug free homes through Oxford House International for individuals in recovery

Objective: Provide recovery housing for individuals in recovery from drug and alcohol addiction

Strategy: Establish new recovery homes statewide

Indicator: Number of new recovery homes

Baseline Measurement: 122 houses

1st yr target/ Outcome: 136 houses

2nd yr target/ Outcome: 148 houses

Data Source: Monthly reports

Description Of Data: Monthly reports give details on established and newly established homes; i.e., location, number of bedrooms, numbers of individuals residing in home, etc.

Data issues/ caveats that Affect outcome: Housing market and possible inability to access

The Health Care System, Parity and Integration - Question 1 and 2 are Required

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.22 Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.23 It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.24

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.25 SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.26 For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.27 Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and

rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.28

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.29 The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.30 Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes31 and ACOs32 may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.33 Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.34

One key population of concern is persons who are dually eligible for Medicare and Medicaid.35 Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.36 SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.37 Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.38 SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with Printed: 8/29/2021 1:17 PM - Tennessee Page 1 of 4 partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.39 Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers,

providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs. SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.40
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.41 However, these jurisdictions should collaborate with federal agencies and their governmental and nongovernmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

22 BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599- 604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102-123 http://www.who.int/bulletin/volumes/91/2/12-108282.pdf ; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52-77

23 Research Review of Health Promotion Programs for People with SMI, 2012, http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper ; About SAMHSA's Wellness Efforts, https://www.samhsa.gov/wellness-initiative ; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, https://www.samhsa.gov/million-hearts-initiative ; Schizophrenia as a health disparity, http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml

24 Comorbidity: Addiction and other mental illnesses, http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-usedisorders-often-co-occur-other-mental-illnesses Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726; https://www.samhsa.gov/find-help/disorders

25 Social Determinants of Health, Healthy People 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39; https://www.cdc.gov/nchhstp/socialdeterminants/index.html

26 https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development

27 http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/

28 Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. https://www.integration.samhsa.gov/integrated-care-models/FGIntegrating,_12.22.pdf ; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011 , https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf ; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf ; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, http://www.aha.org/research/reports/tw/12jan-twbehavhealth.pdf ; American Psychiatric Association, http://www.psych.org/practice/professional-interests/integrated-care ; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210 ; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, http://nasadad.org/nasadad-reports

29 Health Care Integration, http://samhsa.gov/health-reform/health-care-integration ; SAMHSA-HRSA Center for Integrated Health Solutions, (http://www.integration.samhsa.gov/)

30 Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit ; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, https://www.integration.samhsa.gov/operations-administration/telebehavioral-health ; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, http://www.americantelemed.org/home ; National Telehealth Policy Resource Center, https://www.cchpca.org/topic/overview/;

31 Health Homes, http://www.integration.samhsa.gov/integrated-care-models/health-homes

32 New financing models, https://www.integration.samhsa.gov/financing

33 Waivers, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html ; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12- 03-12.pdf

34 What are my preventive care benefits? https://www.healthcare.gov/what-are-my-preventive-care-benefits/ ; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

35 Medicare-Medicaid Enrollee State Profiles, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-MedicaidCoordination-Office/StateProfiles.html ; About the Compact of Free Association, http://uscompact.org/about/cofa.php

36 Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, http://www.cbo.gov/publication/44308

37 BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

38 TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

39 Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.pdf ; Creating jobs by addressing primary care workforce needs, https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n

40 About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm;

41 Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html ; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. *Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.*

TennCare, State Medicaid Authority, launched an initiative called "Tennessee Health Link" (THL). The primary objective of THL is to coordinate health care services for TennCare members with the most significant behavioral health needs. THL is built to encourage the integration of physical and behavioral health, as well as mental health recovery, giving every individual a chance to reach his or her full potential for living a rewarding and increasingly independent life in the community. TDMHSAS and the majority of Community Mental Health Centers (CMHCs) within the state are THL providers. TDMHSAS has worked and will continue to work closely with TennCare and the provider network as this comprehensive integration effort is fully implemented.

Integrated care is promoted through the My Health, My Choice, My Life program. This program is a peer-led health promotion and wellness initiative for Tennesseans who live with mental health and substance use conditions. The holistic health initiative integrates a medical model with recovery and resiliency, resulting in an initiative that focuses on overcoming physical and mental health symptoms through strengths, personal empowerment and resiliency. It is led by peer wellness coaches who have firsthand, lived experience with mental health and substance use disorders and are employed by community mental health providers. My Health, My Choice, My Life provides individuals with self-directed tools, empowering them with the knowledge, skills and resources to improve their overall well-being and resiliency and live healthy and purposeful lives.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with cooccurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

TDMHSAS continues to provide leadership for advancing integrated systems of care for individuals with co-occurring disorders. This is evident through the department's support of the Tennessee Co-Occurring Disorders Collaborative (TNCODC). This multi-agency effort aims to create a common understanding of the impact and treatment of co-occurring disorders in Tennessee communities. The primary goals of TNCODC includes: (1) to share knowledge about the conditions and available resources, (2) reduce stigma, and (3) accurately direct people to timely and effective prevention, treatment, and support.
In addition, TDMHSAS supports its Certified Peer Recovery Specialist program, which currently has 470 CPRS's trained in co-occurring peer support. CPRS have lived experience of mental illness or substance use disorder. A program example of supporting integrated systems of care is through the Statewide Peer Wellness Coach and Trainer program. This program provides and coordinates health and wellness, recovery and peer support training, technical assistance, and on-going support to Peer Support Center staff, Community Behavioral Health Center staff and Certified Peer Recovery Specialists, among others. This training and support assists providers in delivering evidence-based health and wellness programming for people with co-occurring mental and substance use disorders in their communities.

3. *a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans?*
☒ Yes ☐ No
b) and Medicaid?
☒ Yes ☐ No

4. *Who is responsible for monitoring access to M/SUD services provided by the QHP?*

The SMI/SED focused services covered under Tennessee's Block Grant funding are ancillary and fill gaps by providing services not covered by insurance. There has been no initiative yet developed that will monitor access to all behavioral health services in Tennessee. The TennCare program supports a comprehensive benefit array that is provided through subcontracts between three Managed Care Organizations (MCOs) and providers in all three grand regions of Tennessee.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?
☒ Yes ☐ No

6. Do the M/SUD providers screen and refer for:
a) Prevention and wellness education
☒ Yes ☐ No

b) Health risks such as

ii) heart disease
☒ Yes ☒ No

iii) hypertension
☒ Yes ☐ No

iv) high cholesterol
☒ Yes ☒ No

v) diabetes
☒ Yes ☒ No

c) Recovery supports
☒ Yes ☐ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?
☒ Yes ☐ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?
☒ Yes ☐ No

9. *What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?*
Tennessee is facing the following issues related to the implementation and enforcement of parity provisions.

- Increasing awareness of the protections that parity provides.
- Improving understanding of the requirements of parity and of its protections among key stakeholders, including consumers, providers, employers, insurance issuers, and state regulators.
- Increasing the transparency of the compliance process and the support, resources, and tools available to ensure that coverage is in compliance with parity, and concurrently improve the monitoring and enforcement process.

10. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

Health Disparities - Requested

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities42 , Healthy People, 202043 , National Stakeholder Strategy for Achieving Health Equity44, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)45 .

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."46

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status47. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations48. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

42 http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

43 http://www.healthypeople.gov/2020/default.aspx

44 https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

45 http://www.ThinkCulturalHealth.hhs.gov

46 http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

47 https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

48 https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-EthnicityOctober30-1997.pdf

Please respond to the following items: 1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
a) Race
☒ Yes ☐ No
b) Ethnicity
☒ Yes ☐ No
c) Gender
☒ Yes ☐ No
d) Sexual orientation
☐ Yes ☒ No
e) Gender identity
☒ Yes ☐ No
f) Age
☒ Yes ☐ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?
☐ Yes ☒ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?
☒ Yes ☐ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?
☒ Yes ☐ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards?
☒ Yes ☐ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?
☐ Yes ☒ No

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

Innovation in Purchasing Decisions

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C)**

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52] The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices

continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (TIPS)[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

Please respond to the following items:
1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
☒Yes ☐No

2. Which value based purchasing strategies do you use in your state? (check all that apply):
   a) ☐Leadership support, including investment of human and financial resources.
   b) ☒Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c) ☐Use of financial and non-financial incentives for providers or consumers.
   d) ☐Provider involvement in planning value-based purchasing.
   e) ☐Use of accurate and reliable measures of quality in payment arrangements.
   f) ☐Quality measures focus on consumer outcomes rather than care processes.
   g) ☐Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   h) ☐The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Program Integrity

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x–55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

1) Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ☒Yes ☐No

2) Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

☒Yes ☐No

3) Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Primary Prevention - Required SABG

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other

health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and 6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)?
   ☒ Yes ☐ No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) ☒ Yes ☐ No
   a) ☒ Data on consequences of substance-using behaviors
   b) ☒ Substance-using behaviors
   c) ☒ Intervening variables (including risk and protective factors)
   d) ☐ Other (please list)

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
   ☐ Children (under age 12)
   ☒ Youth (ages 12-17)
   ☒ Young adults/college age (ages 18-26)
   ☒ Adults (ages 27-54)
   ☒ Older adults (age 55 and above)
   ☒ Cultural/ethnic minorities
   ☒ Sexual/gender minorities
   ☒ Rural communities
   ☒ Others (please list): Veterans

4.Does your state use data from the following sources in its Primary prevention needs assessment? (check all that apply)
   ☐ Archival indicators (Please list)
   ☒ National survey on Drug Use and Health (NSDUH)
   ☒ Behavioral Risk Factor Surveillance System (BRFSS)

☒ Youth Risk Behavioral Surveillance System (YRBS)
☐ Monitoring the Future
☐ Communities that Care
☐ State - developed survey instrument
☒ Others (please list): Alcohol Epidemiological Data Systems (AEDS), TN Department of Safety and Homeland Security (TDSHS), Fatality Analysis Reporting System (FARS), TN bureau of Investigations, TN Crime Online Website (TBI), Tennessee Council of Juvenile and Family Court Judges (TCJFCJ), TN Department of Mental Health and Substance Abuse Services, 2016 Tennessee Behavioral Health County and Region Services Data Book, TN Bureau of Investigations Lab Data, TN Department of Health, Division of Policy, Planning, and Assessment, Hospital Discharge Data System (HDDS), Neonatal Abstinence Syndrome Surveillance Annual Report 2015, TN Department of Health, Division of Family Health and Wellness (FHW), CDC Wonder, TN Department of Health, Controlled Substance Monitoring Database.

5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds?
☒ Yes ☐ No
If yes, (please explain): Data on consumption patterns, consequences of use, and risk and protective factors are reviewed to formulate a prevention strategic plan that clearly articulates which substances should be targeted and incorporates this information into contracts with coalitions and other grantees. In addition, the State requires each funded agency and coalition to review the data available at the local level and conduct the Strategic Prevention Framework (SPF).

If no, (please explain) how SABG funds are allocated:

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?
   ☒ Yes ☐ No
   If yes, please describe: The Tennessee Certification Board is a statewide entity funded to strengthen the prevention workforce. This entity administers the International Certification and Reciprocity Consortium's Prevention Specialist certification program and helps ensure a high level of prevention competency among the prevention workforce. Every agency funded with prevention block grant dollars is contractually required to have at least one person on staff that has obtained the IC&RC Prevention Specialist credential.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?
   ☒ Yes ☐ No
   If yes, please describe mechanism used: The Tennessee Association of Alcohol and other Drug Abuse Services (TAADAS) is funded to provide training and resources to the prevention workforce. Training topics are identified through an annual survey. TAADAS uses the regional prevention advisory council meetings as a venue to conduct prevention specific trainings. These training events are conducted either before or after the regional meetings and the content of the training event is determined by the prevention providers in the region and are consistent with their organizational needs. DSAS also provides online prevention training and requires that each agency funded with block grant dollars complete two courses each year. These courses have been designed by prevention experts and address the latest in prevention research and science.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?
   ☒ Yes ☐ No
   If yes, please describe mechanism used: The Tennessee Association of Alcohol and other Drug Abuse Services (TAADAS) is funded to provide training and resources to the prevention workforce. Training topics are identified through an annual survey. TAADAS uses the regional prevention advisory council meetings as a venue to conduct prevention specific trainings. These training events are conducted either before or after the regional meetings and the content of the training event is determined by the prevention providers in the region and are consistent with their organizational needs. DSAS also provides online prevention training and requires that each agency funded with block grant dollars complete two courses each year. These courses have been designed by prevention experts and address the latest in prevention research and science.

   The Prevention Alliance of Tennessee (PAT) is a coalition of coalitions funded by the State. This group represents all of the prevention coalitions within Tennessee, both those funded by the State as well as those coalitions who are not funded. The PAT allows coalitions in Tennessee to speak with a collective voice related to prevention issues in the State. The PAT has developed committees that develop white papers around topics important to the prevention system (i.e. marijuana legalization, prescription drug policies, etc.). Additionally, the PAT provides training and technical assistance to coalitions across the State.

   DSAS has also worked to ensure that the state prevention office is well grounded in prevention science. All state prevention staff members have participated in the Substance Abuse Prevention Skills Training and staff regularly participates in conferences to best understand the latest in prevention science. Additionally, staff works to ensure that providers have the tools they need to

1. Ensure that the locations of all permanent prescription drop boxes are communicated to coalitions; 2. Work with other State Departments to design a workable plan; and 3. Incinerate substances. The Office of Prevention Services tries to expand the capacity of coalitions and other providers by providing resources that are timely and meet identified needs. We have started offering annual face-to-face provider meetings where contract requirements are reviewed, but there is also a training component. Also, we are working with Strategic Answers and the National Guard to provide technical assistance to coalitions that best meet their needs.

Every 2 – 3 years TDMHSAS offers the CADCA National Coalition Academy (NCA) to TN substance use prevention coalitions. The NCA is a comprehensive training program developed by CADCA's National Coalition Institute and teaches leaders "what they need to know" (the core competencies) and "what their team needs to do" (the essential processes) to establish or maintain a highly effective substance use prevention coalition. The NCA is designed specifically for coalition staff and volunteer leadership. It combines three weeks of classroom training, three reinforcement on-line sessions and access to a web-based workstation. The Academy's training curriculum is organized within SAMHSA's Strategic Prevention Framework. By the end of the year-long training, in order to graduate, coalitions will have developed five essential products (1) a community assessment, (2) a logic model, (3) a strategic & action plan, (4) an evaluation plan and (5) a sustainability plan.

DSAS is also working collaboratively with the National Guard, Counter Drug Task Force; Civil Operations Unity to provide well-trained and adaptable forces capable of developing substance use prevention coalitions while implementing effective prevention practices. Their vision is to be the preferred source for Technical Assistance for coalitions across the state and for all state agencies involved with the development and training of prevention coalitions by being a force multiplier in a coalition's pursuit to drive positive environmental change in their community and continuously seeking new opportunities to develop effective grassroots coalitions in communities without a drug preventative organization.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

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Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?
   ☐ Yes ☒ No
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ☐ Yes ☐ No ☒ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):
   a) ☐ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   b) ☐ Timelines
   c) ☐ Roles and responsibilities
   d) ☐ Process indicators
   e) ☐ Outcome indicators
   f) ☐ Cultural competence component
   g) ☐ Sustainability component
   h) ☐ Other (please list):
   i) ☒ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?
   ☒ Yes ☐ No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?
   ☒ Yes ☐ No

   If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

   The EBPW reviews training materials and work plan worksheets with TDMHSAS.
   The State working with its Evidence-Based Practice Workgroup (EBPW) on an ongoing basis:
   - Conduct research into health disparities and environmental strategies that are evidence-based for alcohol and establish correlates for impacts on other substances of abuse (e.g. prescription drugs);
   - Conduct discussion groups with coalition staff regarding program implementation to ensure that work products align with evidence based practices;
   - Develop fidelity models for environmental practices for a variety of substances of abuse;
   - Conduct a literature review of evidence-based prevention program
   - Conduct presentations for coalitions and other groups to describe research and make relevant at the practice level; and
   - Develop a menu of evidence-based practices and cite relevant research.

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Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
   a) ☒ SSA staff directly implements primary prevention programs and strategies.
   b) ☒ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
   c) ☒ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
   d) ☒ The SSA funds regional entities that provide training and technical assistance.
   e) ☒ The SSA funds regional entities to provide prevention services.
   f) ☐ The SSA funds county, city, or tribal governments to provide prevention services.
   g) ☒ The SSA funds community coalitions to provide prevention services.
   h) ☒ The SSA funds individual programs that are not part of a larger community effort.
   i) ☐ The SSA directly funds other state agency prevention programs.
   j) ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
   a) Information Dissemination:
      - Tennessee Prevention Network
      - School Based Liaisons
      - Redline and Clearinghouse

- Workforce Training Program
- Community Based Coalitions
- In-Home Visitation Services for At-Risk Mothers
- SAPT Evidence Based Practices Workgroup

b) Education:

- Tennessee Prevention Network
- School Based Liaisons
- Workforce Training Program
- Community Based Coalitions
- In-Home Visitation Services for At-Risk Mother

c) Alternatives:

- Tennessee Prevention Network
- Community Based Coalitions
- Higher Education Coalition

d) Problem Identification and Referral:

- Tennessee Prevention Network
- School Based Liaisons
- Redline and Clearinghouse
- In-Home Visitation Services for At-Risk Mothers
- SAPT Evidence Based Practices Workgroup

e) Community-Based Processes:

- Tennessee Prevention Network
- Community Based Coalitions
- Higher Education Coalition
- SAPT Evidence Based Practices Workgroup

f) Environmental:

- Community Based Coalitions
- School Based Liaisons

2. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?
   ☒ Yes ☐ No

   If yes, please describe:

   DSAS ensures that SABG dollars are used to fund primary substance abuse prevention services by including language within prevention contracts that defines “primary prevention” and explicitly stating that prevention funding can only be used for primary prevention. Additionally, training is provided each year to ensure agencies understand the requirement; and agencies are monitored against their contract during regularly scheduled monitoring visits. The Tennessee Department of Mental Health and Substance Abuse Services conduct programmatic and fiscal monitoring visits on all providers at least once over a three-year period. Programmatic monitoring visits assess

achievement of contract performance benchmarks through the examination of personnel and service recipient records and data management as well as evaluation of conformity with agency policies and procedures and DSAS requirements. The fiscal monitoring visit is conducted in accordance to the Tennessee Department of General Services Policy 2013-007, Subrecipient Monitoring. The objectives for the fiscal review include a test to determine if costs and services are allowable and eligible; and to verify contractual compliance. In addition, there is a special term and condition in all grant contracts prohibiting supplanting of SABG funds.

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Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?

   ☐ Yes ☒ No

2. Does your state's prevention evaluation plan include the following components? (check all that apply):
   a) ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
   b) ☐ Includes evaluation information from sub-recipients
   c) ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
   d) ☐ Establishes a process for providing timely evaluation information to stakeholders
   e) ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   f) ☐ Other (please list:)
   g) ☒ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:
   a) ☒ Numbers served

b) ☒ Implementation fidelity
c) ☐ Participant satisfaction
d) ☒ Number of evidence-based programs/practices/policies implemented
e) ☒ Attendance
f) ☒ Demographic information
g) ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

a) ☒ 30-day use of alcohol, tobacco, prescription drugs, etc
b) ☒ Heavy use
☒ Binge use
☒ Perception of harm
c) ☐ Disapproval of use
d) ☒ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
e) ☐ Other (please describe):

Substance Use Disorder Treatment

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs.
Improving access to treatment services

1. Does your state provide:

a) A full continuum of services:
i) Screening
☐**Yes** ☐**No**
ii) Education
☒**Yes** ☐**No**
iii) Brief intervention
☒**Yes** ☐**No**
iv) Assessment
☒**Yes** ☐**No**
v) Detox (inpatient/social)
☒**Yes** ☐**No**
vi) Outpatient
☒**Yes** ☐**No**
vii) Intensive outpatient
☒**Yes** ☐**No**
viii) Inpatient/residential
☒**Yes** ☐**No**
ix) Aftercare; recovery support
☒**Yes** ☐**No**
b) Services for special populations:
Targeted services for veterans?
☐**Yes** ☒**No**
Adolescents?
☒**Yes** ☐**No**
Older adults?

☐**Yes** ☒**No**
Medication-Assisted Treatment (MAT)?
☒**Yes** ☐N**o**

Criterion 2: Improving Access and Addressing Primary Prevention – See Narrative 8. Primary Prevention-Required SABG.

Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)
1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability?
a) ☒Yes ☐No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?
a) ☒Yes ☐No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?
a) ☒**Yes** ☐**No**

4. Does your state have an arrangement for ensuring the provision of required supportive services?
a) ☒**Yes** ☐N**o**

5. Has your state identified a need for any of the following:
a) Open assessment and intake scheduling?
☐**Yes** ☒**No**
b) Establishment of an electronic system to identify available treatment slots?
☒**Yes** ☐**No**
c) Expanded community network for supportive services and healthcare?
☐**Yes** ☒**No**
d) Inclusion of recovery support services?
☒**Yes** ☐**No**
e) Health navigators to assist clients with community linkages?
☐**Yes** ☒**No**
f) Expanded capability for family services, relationship restoration, and custody issues?
☒**Yes** ☐N**o**
g) Providing employment assistance?
☒**Yes** ☐**No**
h) Providing transportation to and from services?
☒**Yes** ☐**No**
i) Educational assistance?
☐**Yes** ☒**No**

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.
Monitoring program compliance is a contractual requirement for all funded providers.

<u>Monitoring</u>. In accordance with Section D.16., the State shall conduct program monitoring as follows:
(1) State monitors shall notify the Grantee of their arrival, prior to site visit inception. The Grantee shall make available all relevant personnel on the appointed day and at the scheduled time chosen by the

State, unless otherwise arranged with the State. Deviations from the proposed site visit date must be approved by the State no later than two (2) weeks prior to the site visit date;

(2) The Grantee shall comply with any and all requests for information as issued by the State and is required to have all information slated for review, present and ready for review on the appointed day and at the scheduled time of the review. All requested information is to be prepared as specified by the State;

(3) Following the monitoring visit or desk review, the Grantee shall receive a Monitoring Report. If the Monitoring Report indicates that the Grantee has incurred reportable findings, the Grantee shall be required to submit a Corrective Action Plan (CAP) for the State's approval. The CAP must include the date issued, the signature of the preparer, and must address each reportable finding listed in the Monitoring Report. The CAP must also include corrective action to be implemented, person responsible for implementing corrective action, and the CAP implementation date;

(4) Grantee correspondence concerning the CAP may be submitted to the State in hard copy or electronically, as an attachment, via electronic mail (e-mail); and must include a cover letter on Grantee letterhead; and must conform to the State approved format; and must be submitted within the timeframe specified by the State. No facsimile CAP information will be accepted; and

(5) If the CAP is satisfactory, the Grantee shall receive a CAP Approval Letter from the State. If the CAP is unsatisfactory, the Grantee shall receive a CAP Disapproval Letter requesting amendment and resubmission to the State. After the CAP is approved, the State shall conduct a follow-up site visit within sixty (60) days after the approval of the CAP. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Grant Contract as specifically indicated herein.

Criteria 4, 5 and 6: Persons Who Inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:
   a) 90 percent capacity reporting requirement?
   ☒**Yes** ☐**No**
   b) 14-120 day performance requirement with provision of interim services?
   ☒**Yes** ☐**No**
   c) Outreach activities?
   ☒**Yes** ☐**No**
   d) Syringe services programs?
   ☐**Yes** ☒**No**
   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation?
   ☒**Yes** ☐**No**

2. Has your state identified a need for any of the following:
   a) Electronic system with alert when 90 percent capacity is reached?
   ☐**Yes** ☒**No**
   b) Automatic reminder system associated with 14-120 day performance requirement?

☐**Yes** ☒**No**

c) Use of peer recovery supports to maintain contact and support?

☒**Yes** ☐**No**

d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?

☒**Yes** ☐**No**

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Monitoring program compliance is a contractual requirement for all funded providers.

Monitoring. In accordance with Section D.16., the State shall conduct program monitoring as follows:

(1) State monitors shall notify the Grantee of their arrival, prior to site visit inception. The Grantee shall make available all relevant personnel on the appointed day and at the scheduled time chosen by the State, unless otherwise arranged with the State. Deviations from the proposed site visit date must be approved by the State no later than two (2) weeks prior to the site visit date;

(2) The Grantee shall comply with any and all requests for information as issued by the State and is required to have all information slated for review, present and ready for review on the appointed day and at the scheduled time of the review. All requested information is to be prepared as specified by the State;

(3) Following the monitoring visit or desk review, the Grantee shall receive a Monitoring Report. If the Monitoring Report indicates that the Grantee has incurred reportable findings, the Grantee shall be required to submit a Corrective Action Plan (CAP) for the State's approval. The CAP must include the date issued, the signature of the preparer, and must address each reportable finding listed in the Monitoring Report. The CAP must also include corrective action to be implemented, person responsible for implementing corrective action, and the CAP implementation date;

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(5) If the CAP is satisfactory, the Grantee shall receive a CAP Approval Letter from the State. If the CAP is unsatisfactory, the Grantee shall receive a CAP Disapproval Letter requesting amendment and resubmission to the State. After the CAP is approved, the State shall conduct a follow-up site visit within sixty (60) days after the approval of the CAP. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Grant Contract as specifically indicated herein.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?

a) ☒**Yes** ☐**No**

2. Has your state identified a need for any of the following:
   a) Business agreement/MOU with primary healthcare providers?
   ☐**Yes** ☒**No**
   b) Cooperative agreement/MOU with public health entity for testing and treatment?
   ☐**Yes** ☐**No**
   c) Established co-located SUD professionals within FQHCs?
   ☐**Yes** ☒**No**

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems. Monitoring program compliance is a contractual requirement for all funded providers.

Monitoring. In accordance with Section D.16., the State shall conduct program monitoring as follows:

(1) State monitors shall notify the Grantee of their arrival, prior to site visit inception. The Grantee shall make available all relevant personnel on the appointed day and at the scheduled time chosen by the State, unless otherwise arranged with the State. Deviations from the proposed site visit date must be approved by the State no later than two (2) weeks prior to the site visit date;

(2) The Grantee shall comply with any and all requests for information as issued by the State and is required to have all information slated for review, present and ready for review on the appointed day and at the scheduled time of the review. All requested information is to be prepared as specified by the State;

(3) Following the monitoring visit or desk review, the Grantee shall receive a Monitoring Report. If the Monitoring Report indicates that the Grantee has incurred reportable findings, the Grantee shall be required to submit a Corrective Action Plan (CAP) for the State's approval. The CAP must include the date issued, the signature of the preparer, and must address each reportable finding listed in the Monitoring Report. The CAP must also include corrective action to be implemented, person responsible for implementing corrective action, and the CAP implementation date;

(4) Grantee correspondence concerning the CAP may be submitted to the State in hard copy or electronically, as an attachment, via electronic mail (e-mail); and must include a cover letter on Grantee letterhead; and must conform to the State approved format; and must be submitted within the timeframe specified by the State. No facsimile CAP information will be accepted; and

(5) If the CAP is satisfactory, the Grantee shall receive a CAP Approval Letter from the State. If the CAP is unsatisfactory, the Grantee shall receive a CAP Disapproval Letter requesting amendment and resubmission to the State. After the CAP is approved, the State shall conduct a follow-up site visit within sixty (60) days after the approval of the CAP. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Grant Contract as specifically indicated herein.

Early Intervention Services for HIV (For "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery?
☐Yes ☒No Currently not a designated state

2. Has your state identified a need for any of the following:
a) Establishment of EIS-HIV service hubs in rural areas?
☐Yes ☐No

b) Establishment or expansion of tele-health and social media support services?
☐Yes ☐No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS?
☐Yes ☐No

Syringe Service Programs
1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes (42 U.S.C.§ 300x-31(a)(1)F)?
☒Yes ☐No

2) Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?
☒Yes ☐No

3) Do any of your programs use SABG funds to support elements of a Syringe Services Program?
a) ☐Yes ☒No
b) If yes, please provide a brief description of the elements and the arrangement

Criteria 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

Service System Needs
1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement?
☒Yes ☐No

2. Has your state identified a need for any of the following:
a) Workforce development efforts to expand service access?
☐Yes ☒No
b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services?
☐Yes ☒No
c) Establish a peer recovery support network to assist in filling the gaps?
☐Yes ☒No
d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)
☐Yes ☒No
e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations
☐Yes ☒No
f) Explore expansion of services for:

i) MAT
(1) ☐Yes ☒No
ii) Tele-health
(1)☒Yes ☐No
iii) Social media outreach
(1)☐Yes ☒No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? **☐Yes ☒No**

2. Has your state identified a need for any of the following:
a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
☐Yes ☒No
b) Establish a program to provide trauma-informed care
☒Yes ☐No
c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education
☒Yes ☐No

Charitable Choice
1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)?
☒Yes ☐No
2. Does your state provide any of the following:
a) Notice to Program Beneficiaries?
☒Yes ☐No
b) An organized referral system to identify alternative providers?
☒Yes ☐No
c) A system to maintain a list of referrals made by religious organizations?
☐Yes ☒No

Referrals
1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?
☒Yes ☐No
2. Has your state identified a need for any of the following:
a) Review and update of screening and assessment instruments?
☐Yes ☒No
b) Review of current levels of care to determine changes or additions?
☐Yes ☒No
c) Identify workforce needs to expand service capabilities?
☒Yes ☐No
d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background?
☒Yes ☐No

Patient Records

1. Does your state have an agreement to ensure the protection of client records?
   a) ☒**Yes** ☐**No**
2. Has your state identified a need for any of the following:
   a) Training staff and community partners on confidentiality requirements?
   ☒**Yes** ☐**No**
   b) Training on responding to requests asking for acknowledgement of the presence of clients?
   ☒**Yes** ☐**No**
   c) Updating written procedures which regulate and control access to records?
   ☒**Yes** ☐**No**
   d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure?
   ☐**Yes** ☒**No**

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?
   a) ☒**Yes** ☐**No**

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.
   a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved. Four (4)

3. Has your state identified a need for any of the following:
   a) Development of a quality improvement plan?
   ☐**Yes** ☒**No**
   b) Establishment of policies and procedures related to independent peer review?
   ☐**Yes** ☒**No**
   c) Development of long-term planning for service revision and expansion to meet the needs of specific populations
   ☐**Yes** ☒**No**

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?
   a) ☐**Yes** ☒**No We don't require but we do encourage.**
   b) **If Yes,** please identify the accreditation organization(s)
      i) ☐Commission on the Accreditation of Rehabilitation Facilities
      ii) ☐The Joint Commission
      iii) ☐Other (please specify)_____

Criterion 7 and 11: Group Homes for Persons In Recovery and Professional Development

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?
☒**Yes** ☐**No**

2. Has your state identified a need for any of the following:
   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service?

☐**Yes** ☒**No**

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing?

☐**Yes** ☒**No**

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state?

☒**Yes** ☐**No**

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services?

☒**Yes** ☐**No**

c) Performance-based accountability?

☐**Yes** ☒**No**

d) Data collection and reporting requirements?

☒**Yes** ☐**No**

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs?

☒**Yes** ☐**No**

b) Addition of training sessions designed to increase employee understanding of recovery support services?

☐**Yes** ☒**No**

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services?

☒**Yes** ☐**No**

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort?

☒**Yes** ☐**No**

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC?

☐**Yes** ☒**No**

b) Mental Health TTC?

☐**Yes** ☒**No**

c) Addiction TTC?

☒**Yes** ☐**No**

d) State Targeted Response TTC?

☒**Yes** ☐**No**

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924 and 1928 (42 U.S.C. § 300x-32(f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations Regarding Women

☐**Yes** ☒**No**

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus

a) Tuberculosis

☐**Yes** ☒**No**

b) Early Intervention Services Regarding HIV
☐**Yes** ☒**No**
3. Additional Agreements
a) Improvement of Process for Appropriate Referrals for Treatment
☐**Yes** ☒**No**
b) Professional Development
☐**Yes** ☒**No**
c) Coordination of Various Activities and Services
☐**Yes** ☒**No**

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs:

Rules of the Tennessee Department of Mental Health and Substance Abuse Services
https://publications.tnsosfiles.com/rules/0940/0940.htm

Tennessee Code Annotated Title 33, Chapter 10
http://www.lexisnexis.com/hottopics/tncode/

Quality Improvement Plan

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

1. Has your state modified its CQI plan from FFY 2018-FFY 2019?
a) ☐**Yes** ☒**No**

Please indicate areas of technical assistance needed related to this section.

Trauma

Trauma 57 is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal

histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often retraumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services. It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma58 paper.

57 Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. 58 Ibid

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?
   ☒ Yes ☐ No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?
   ☒ Yes ☐ No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?
   ☐ Yes ☒ No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?
   ☒ Yes ☐ No
5. Does the state have any activities related to this section that you would like to highlight.

   All DSAS funded providers are required to provide a screening and assessment for trauma and ensure that treatment meets the needs of those identified as having experienced trauma. The provider can use the AC-OK Adult Screen for trauma or another trauma screen from the SAMHSA's Evidence Based Practices Resource Center on each service recipient upon initial contact. The provider is also required to complete a brief trauma screener in TNWITS (our web-based information system) if trauma is identified during the administration of the ASI.

   Please indicate areas of technical assistance needed related to this section.

Criminal and Juvenile Justice - Requested

Narrative Question
More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.59

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.60

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

59 Journal of Research in Crime and Delinquency: : Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. OJJDP Model Programs Guide
60 http://csgjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?
   ☒ Yes ☐ No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?
   ☒ Yes ☐ No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?
   ☒ Yes ☐ No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

☒ Yes ☐ No

5. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

Medication Assisted Treatment - Requested (SABG only)

Narrative Question
There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49 [4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.
TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]
TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]
TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]
TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]
TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

Please respond to the following items:
1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?
☒ Yes ☐ No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?
☒ Yes ☐ No

3. Does the state purchase any of the following medication with block grant funds?
a) Methadone
☐ Yes ☒ No
b) Buprenorphine, Buprenorphine/naloxone
☐ Yes ☒ No
c) Disulfiram
☐ Yes ☒ No
d) Acamprosate
☐ Yes ☒ No
e) Naltrexone (oral, IM)
☐ Yes ☒ No

f) Naloxone
☐ Yes ☒ No

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*?
☒ Yes ☐ No

5. Does the state have any activities related to this section that you would like to highlight?

DSAS has been able to expand medication assisted treatment through state funding as well as federal discretionary grant funding to include all three forms of the FDA- approved medications -- naltrexone, buprenorphine, and methadone for the indigent population. There are also plans to provide the injectable form of buprenorphine (Sublocade) through discretionary funding.

*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Crisis Services

In the on-going development of efforts to build a robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families.

According to SAMHSA's publication, *Practice Guidelines: Core Elements for Responding to Mental Health Crises*[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

1. Crisis Prevention and Early Intervention
   a) ☒Wellness Recovery Action Plan (WRAP) Crisis Planning
   b) ☒Psychiatric Advance Directives
   c) ☒Family Engagement
   d) ☒Safety Planning

e) ☒Peer-Operated Warm Lines
f) ☐Peer-Run Crisis Respite Programs
g) ☒Suicide Prevention

2. Crisis Intervention/Stabilization:
a) ☒Assessment/Triage (Living Room Model)
b) ☐Open Dialogue
c) ☒Crisis Residential/Respite
d) ☒Crisis Intervention Team/ Law Enforcement
e) ☒Mobile Crisis Outreach
f) ☒Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support:
a) ☒Peer Support/Peer Bridgers
b) ☒Follow-Up Outreach and Support
c) ☒Family-to-Family engagement
d) ☒Connection to care coordination and follow-up clinical care for individuals in crisis
e) ☒Follow-up crisis engagement with families and involved community members)
f) ☐Recovery community coaches/peer recovery coaches
g) ☐Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

Recovery

Narrative Question
The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:
• Recovery emerges from hope;
• Recovery is person-driven;
• Recovery occurs via many pathways;

• Recovery is holistic;
• Recovery is supported by peers and allies;
• Recovery is supported through relationship and social networks;
• Recovery is culturally-based and influenced;
• Recovery is supported by addressing trauma;
• Recovery involves individuals, families, community strengths, and responsibility;
• Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.
Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

1. Does the state support any of the following:
a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?
☒ Yes ☐ No
b) Required peer accreditation or certification?
☒ Yes ☐ No
c) Block grant funding of recovery support services.
☒ Yes ☐ No
d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?
☒ Yes ☐ No

2. Does the state measure the impact of your consumer and recovery community outreach activity?
☐ Yes ☒ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.
N/A

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. TDMHSAS considers recovery support to be a vital component in the pathway to recovery for individuals with substance use and co-occurring disorders. Recovery Support Services are services provided to promote individual, program, and system-level approaches that foster health and resilience, increase permanent housing, employment and other

necessary supports, and reduce barriers to social inclusion. TDMHSAS provides opportunity for recovery support for adults including women and pregnant women as well as adolescent.

5. Does the state have any activities that it would like to highlight?

TDMHSAS offers Recovery Activities in its array of services. Recovery activities may include cultural activities, community events, and other similar activities. Many of the recovery support providers report that the clients are very engaged in choosing these activities and see this as an effective tool in "teaching" that recovery can be fun.

Please indicate areas of technical assistance needed related to this section.

Children and Adolescents M/SUD Services

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64] For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their

family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67]

According to data from the 2015 Report to Congress[68] on systems of care, services:

1 reach many children and youth typically underserved by the mental health system;
2 improve emotional and behavioral outcomes for children and youth;
3 enhance family outcomes, such as decreased caregiver stress;
4 decrease suicidal ideation and gestures;
5 expand the availability of effective supports and services; and
6 save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

Please respond to the following:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED?
   ☒Yes ☐No
   b) The recovery and resilience of children and youth with SUD?
   ☒Yes ☐No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs
   a) Child welfare?
   ☒Yes ☐No
   b) Juvenile justice?
   ☒Yes ☐No
   c) Education?
   ☒Yes ☐No

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization?
   ☒Yes ☐No
   b) Costs?
   ☒Yes ☐No
   c) Outcomes for children and youth services?
   ☒Yes ☐No

4. Does the state provide training in evidence-based :

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?
☐Yes ☐No
b) Mental health treatment and recovery services for children/adolescents and their families?
☒Yes ☐No

5. Does the state have plans for transitioning children and youth receiving services:
a) to the adult M/SUD system?
☐Yes ☐No
b) for youth in foster care?
☒Yes ☐No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The State of Tennessee provides integrated services through partnerships that have been developed throughout the state since the adoption of system of care in 1999. The system of care in Tennessee is governed by the legislatively mandated Council on Children's Mental Health (CCMH), which brings together individuals from across the state to discuss systems, projects, and programs that touch the lives of children and youth with mental health concerns. CCMH provides a venue, five times annually, for child serving agencies to discuss current trends within the state as well as potential barriers to service. The council has various ad hoc committees that identify and problem-solve issues around financing, policy, community readiness, marketing, and other areas related to the promotion of system of care across Tennessee. In addition to CCMH, there are numerous advisory boards, councils, and committees that system of care is represented to work toward improving the lives of young children, children, youth, young adults, and families across the state including: the Youth Transition Advisory Council, Healthy Transitions State Transition Team, Young Child Wellness Council, Association for Infant Mental Health in Tennessee, and the Tennessee Council on Autism Spectrum Disorder. System of care in Tennessee provides training on the use of high-fidelity wraparound which will further integrate services by providing wraparound services to children and families by bringing together systems to work toward a single treatment plan among child-serving agencies. Several of the department's children and youth programs offer integrated services at the local level by working with schools, the juvenile justice system, and child welfare services. Through the work of System of Care Across Tennessee TDMHSAS was able to secure $21 million in funding to expand the System of Care until 2024, $12 million in federal SAMHSA funding and $9 million interagency funding with the Department of Human Services Temporary Assistance for Needy Families (TANF) program.

TDMHSAS partners with Tennessee Department of Education on a SAMHSA Project AWARE-SEA (Advancing Wellness and Resiliency in Education-State Education Agency) grant, which expanded school-based mental health services to students in high-need school districts in Tennessee.

In the most recent legislative session Governor Lee announced a $250 million mental health trust fund to be used to expand mental health services across the state.

In August, an Announcement of Funding (AOF) is set to be released for the Tennessee Resiliency Project (TRP) to provide an additional $6.5 million in funding to increase resiliency in early childhood, school based, and crisis continuum settings.

7. Does the state have any activities related to this section that you would like to highlight?

The work of system of care in Tennessee has been occurring for the last twenty years and remains strong throughout the state and its values and principles are infused in multiple programs within TDMHSAS. System of Care Across Tennessee provides for a comprehensive training and technical assistance center which assists in moving the system of care philosophy forward in Tennessee through training, support, and resources for families, providers, and community members.

The Children and Youth Homeless Outreach Project aims to identify and provide outreach services for the purpose of linking children with Serious Emotional Disturbance (SED) or children at risk of SED who are experiencing homelessness or at risk of homelessness, and their caregivers to mental health and housing services. The program provides services that help to prevent homelessness or positively affect the quality of life for the service recipients and their families/caregivers and help to keep the family unit intact. Outreach efforts and services include active engagement with qualifying children and families/caregivers, establishing positive working partnerships with area shelters, strengthening relationships with the local HUD Continuums of Care, collaborating with faith-based communities, fostering strong communication with schools, partnering with local social services agencies and organizations, building collaborative relationships with homeless outreach workers outside of the program, advocacy efforts within the community, and disseminating information related to available mental health services. Additionally, this program can provide limited, one-time financial support for immediate needs that can avert homelessness or imminent risk of homelessness, e.g., rent deposit, emergency food or household items.

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

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Term: 7/01/21 to 6/30/24

Advisory Council Composition by Member Type

Total Membership = 47

Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)
Number: 7

Family Members of Individuals in Recovery* (to include family members of adults with SMI)
Number: 9

Parents of children with SED/SUD*
Number: 3

Vacancies (Individuals and Family Members)
Number: 0

Others (Advocates who are not State employees or providers)
Number: 5

Persons in recovery from or providing treatment for or advocating for SUD services
Number: 1

Representatives from Federally Recognized Tribes
Number: 0

Total Individuals in Recovery, Family Members & Others
Number: 25
Percentage: 53.19%

State Employees
Number: 9

Providers
Number: 13

Vacancies
Number: 0

Total State Employees & Providers
Number: 22
Percentage: 46.81%

Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations
Number: 0

Providers from Diverse Racial, Ethnic, and LGBTQ Populations
Number: 0

Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations
Number: 0

Youth/adolescent representative (or member from an organization serving young people)
Number: 1

Public Comment on the State Plan

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:
1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings?
☐ Yes ☒ No
b) Posting of the plan on the web for public comment?
☒ Yes ☐ No

If yes, provide URL: https://www.tn.gov/behavioral-health/substance-abuse-services/blockgrant

c) Other (e.g. public service announcements, print media)
☐ Yes ☒ No

Public comment for the SABG is solicited through both public availability and direct distribution of the draft plan to members of the Tennessee Department of Mental Health Planning and Policy Council, substance abuse prevention and treatment contract providers, TDMHSAS executive staff, any other individuals or organizations requesting access and the general public. The Statewide Planning and Policy Council assists in planning a comprehensive array of high quality prevention, early intervention, treatment, and habilitation services and supports, and to advise the Department on policy, budget requests, and developing and evaluating services and supports. (T.C.A. §33-1-401). Copies of the FY 2022-23 Block Grant draft application were e-mailed to members of the groups mention above and a link was posted on the Tennessee Web-based Information Technology System and Department's website homepage for general public access, review and comment during the development of the plan and submission to HHS. Comments can be directed to Bev Fulkerson, Deputy Assistant Commissioner and Block Grant Coordinator, Division of Substance Abuse Services at bev.fulkerson@tn.gov.